ISLAND HEALTH

Special Consent to Operation, Post Operative Care, Medical Treatment, Anesthesia, or other procedure

Patient: _____ DOB: _____ Medical Record Number: _____

Washington State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1) I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by said physician to treat the following condition(s) which has (have) been explained to me: (Explain the nature of the condition(s) in professional and lay language.)

2) The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand them to be: (Describe procedures to be performed in professional and lay language.)

At: Island Hospital and/or Island Hospital Clinics

3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. **I therefore authorize my above named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her or their professional judgment necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

4) **I have been informed that there are significant risks** such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. **I acknowledge that no warranty or guarantee has been made to me as a result or cure.**

IMPORTANT: HAVE PATIENT SIGN FULL OR LIMITED DISCLOSURE BOX AND SIGNATURE LINE AT BOTTOM.

Full Disclosure

I certify that my physician has informed me of the nature and character of the medical procedure or surgery described on this form, including its possible significant risks, complications and anticipated results; and the alternative forms of treatment, including non-treatment, and their significant risks, complications and anticipated results.

_____

Patient / Other Legally Responsible Person Sign If Applicable

Limited Disclosure

I certify that my physician has explained to me that I have the right to have clearly described to me the nature and character of the proposed medical procedure or surgery described on this form, including its possible significant risks, complications and anticipated results; and the alternative forms of treatment, including non-treatment, and their significant risks, complications and anticipated results.

I do not wish to have these risks and facts explained to me.

_____

Patient / Other Legally Responsible Person Sign If Applicable

*Any sections below that do not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by **both** physician **and** patient.*

5) I consent to the administration of anesthesia by my attending physician, by an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risk of complications and serious possible damage to vital organs such as the brain, heart, lungs, liver, kidney and nerve injury and that in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

6) I consent to the transfusion of blood and blood products as deemed necessary. I have been given a handout detailing the risks, benefits, and alternatives of blood transfusions.

7) Any tissues or parts surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

8) I consent to HIV testing in the event that a staff member has an exposure to my blood or body fluids during or following surgery.

Physician's Statement

The medical procedure or surgery stated on this form, including possible risks, complications, alternative treatments (including non-treatment) and anticipated results, was explained by me to the patient or his/her representatives before the patient or his/her representatives consented.

Physician's Signature: _____ **Date:** _____ **Time:** _____

Patient or Patient Representative's Acknowledgement

I acknowledge that I have read (or have had read to me) and fully understand the above consent, the explanations referred to were made, and all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

Signature of Patient
Or Patient Representative: _____ **Date:** _____ **Time:** _____

Witness Acknowledgement

I acknowledge that I, as witness, have identified the above individual and I have observed his/her signature on this document.

Witness Signature: _____ **Date:** _____ **Time:** _____

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