CONSENT FOR SURGERY OR OTHER INVASIVE PROCEDURAL TREATMENT

The law in Washington State gives you the right and responsibility to make decisions about your health care. Doctors can give you information and advice, but as a member of the healthcare team, you or your legal representative must be part of the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. I hereby give permission to Dr. ______________________________ and such associates as my doctor may choose, including associates or residents (doctors who have finished medical school, but are getting more training) to assist with part or all of my procedure(s). I understand that assisting may involve such tasks as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissues.

2. The procedure(s) planned for treatment of my condition(s) has (have) been explained to me by my doctor. The procedure(s) as I understand it (them) to be is (are):

____

____

3. My doctor has explained to me to the degree that I wish to have it discussed, the kind of procedure and what it will involve. I have been told about the known, serious risks and complications of this procedure. Any operation or procedure involves some risks and hazards. The common risks include stroke, device failure, infection, nerve injury, blood clots, heart attack, allergic reactions, respiratory failure, kidney failure, bleeding, severe blood loss, and risks of blood transfusions. These risks can be serious and possibly fatal. I have been told about other treatment options and about their risks and benefits, including not having the procedure. I have been told about what results to expect, which includes information about the chances for the expected results. I know that results cannot be guaranteed. I understand that my doctor may need to perform other urgent procedures due to an unexpected circumstance during my procedure. I give my permission for the doctor to do so.

4. My doctor may also allow observers who are not going to be assisting him/her with my procedure, including other doctors, students of health care programs and suppliers of medical device(s) to be used in my procedure(s). I give permission for such observers.

5. My doctor has advised me that I will receive either anesthesia or sedation medicine, or both. I understand that there are risks and side effects associated with anesthesia and sedation and that these risks and side effects will be discussed with me by my anesthesiologist before I have my procedure.

6. My doctor has explained that blood or blood products may need to be used (also known as transfused). I have been told about side effects and risks, including allergic reactions, fever, hives, lung injury, and in rare cases, infectious diseases such as hepatitis and HIV/AIDS, and other options for treatment, such as anemia management, blood conservation, or not getting a transfusion.

______________ **I do not consent to blood transfusion. If refusing blood, patient must sign *Consent for Non Blood Medical Management.***
(PATIENT'S INITIALS)

7. I accept that any specimens, such as tissue, blood, bodily fluids, etc. may be disposed of or may be stored and used for future medical studies or research. Any research involving your specimens will be reviewed by an institutional review board and may be reviewed by the U.S. Food and Drug Administration.

I have had sufficient opportunity to discuss my condition and treatment with my physician(s) and/or their associates, and all of my questions have been answered to my satisfaction. I believe I have been given enough information upon which to make an informed decision about undergoing the recommended treatment. I understand I should not sign this form until all my questions have been answered to my satisfaction and until I understand all the words or terms on this form. I have read and fully understand this form and I voluntarily authorize and consent to this operation/procedure or treatment. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand that I am free to refuse consent to any procedure. I hereby give my consent for the above procedure(s).

Date/Time	
SIGNATURE (PATIENT or AUTHORIZED REPRESENTATIVE)	RELATIONSHIP
PRINT NAME	

WITNESS TO CONSENT (Signature)	PRINT NAME

PHYSICIAN'S STATEMENT

I have explained the contents of this document to the patient/legal representative and have answered all the patient's questions, and to the best of my knowledge, I feel this patient has been adequately informed and has consented.

Date/Time	
PHYSICIAN SIGNATURE	PRINT NAME

ADDRESSOGRAPH

SWEDISH MEDICAL CENTER
SEATTLE, WASHINGTON

Form 21 Stock Rev. 12/07 (FV)