I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests and where delay might impair my health.

If an exploratory operation is proposed, I have been informed of possible conditions that may be discovered and I consent to performance of procedure(s) as determined by my physician to be in my best interest.

1. I authorize Dr. ____________________________, and such physicians in training and assistants as she/he may select, to treat my condition, including performing further diagnosis and the procedures described below. I hereby consent to the taking of pictures, television recordings or videotape recordings of medical or surgical conditions or procedures and for use of such pictures or films for educational purposes, without expense to me.

2. I understand the procedure to be performed is __________________________________________

3. My doctor explained to me the procedure(s) or treatment(s), the anticipated benefits, the material risks, and alternative therapies, including risks with a high degree of likelihood but a low degree of severity as well as those with a very low degree of likelihood but high degree of severity.

4. I also understand that there may be other risks or complications, serious injury, or even death from both known and unknown causes. 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 risks of the procedure.

5. I understand and agree that any tissues or parts removed may be disposed of by the hospital authorities in accordance with accustomed practice except: __________________________________________________________________________

6. I understand that the transfusion of blood and/or blood products may be required for me during the course of the above-named procedure and I voluntarily consent and authorize transfusion. I understand that no warranty or guarantee has been made to me as to result or care. I also realize that the following risks and hazards may occur in connection with blood transfusion, including but not limited to: fever, transfusion reaction that may include kidney failure or anemia, heart failure, hepatitis, HIV, and other infections.

☐ I refuse the transfusion of blood and/or blood products, even if the results are life threatening._____________________

7. Consent for Serial Procedures (complete when appropriate)

☐ I consent to the above as a series of the same procedure over a time period from ______/______/______ to ______/______/______

8. Vendor Presence: (Check box if applicable)

☐ I understand that a vendor or medical equipment representative may be present during the performance of my procedure. Presence shall be limited to providing information for coordination of treatments, such as advice or education on medical device specifications and selection for proper sizing during the procedure, and providing technical expertise on the implant, use and operation of the vendor’s equipment, by operating programmers, analyzers and other support equipment under the supervision of my physician.
9. I hereby authorize the release of my Social Security Number to the manufacturer of the medical device that I am to receive in accordance with the Federal Food, Drug and Cosmetic Act Section 519(e). I further understand that the manufacturer may need to contact me with regard to this medical device and may use my Social Security Number to locate me.

10. **For DNR patients:** The likelihood that I will require CPR during my procedure or in the recovery room has been fully discussed with me. I understand the CPR measures that may be required, the chance of success of those methods, and the possible outcomes with or without CPR. Based on this information, I ask that my Do Not Resuscitate (DNR) order 1) **be suspended in the OR and in recovery**; or 2) **continue in effect in the OR and in recovery**. If suspended, I ask that the DNR order be reinstated once I have been transferred from recovery.

**PATIENT OR PARENT / LEGAL REPRESENTATIVE CERTIFICATION:**
By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.

____________________  ______________________
SIGNATURE OF PATIENT  DATE & TIME
If patient is a minor, incompetent or unable to give consent:

____________________  ______________________
SIGNATURE OF RESPONSIBLE PARTY  DATE & TIME

**RELATIONSHIP TO PATIENT OR LEGAL AUTHORIZATION**

**PHYSICIAN ATTESTATION**
I, or a member of my practice, have explained the procedure(s), alternative(s) and risks to the person or persons whose signature is affixed above. The patient and/or their legal representative has verbally communicated to me that they understand the contents of this form.

____________________  ______________________
SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT / PHYSICIAN NO  DATE & TIME

**INTERPRETER ATTESTATION (when applicable)**
I have provided translation to the person(s) whose signature(s) is/are affixed above.

____________________  ______________________
SIGNATURE OF INTERPRETER/LANGUAGE LINE OPERATOR NUMBER  DATE & TIME

____________________  ______________________
TELEPHONE CONSENT WITNESS SIGNATURE  DATE & TIME