COFFEE REGIONAL MEDICAL CENTER

CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURES

3CNT

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

A. (1) I acknowledge and understand that the following procedures which have been described to me are to be performed on the patient:

_____

_____

_____

and that as a result of the performance of the procedures there is a material risk that the patient may suffer INFECTION, ALLERGIC REACTION, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, DISFIGURING SCAR OR BRAIN DAMAGE, CARDIAC ARREST, OR DEATH.

(2) I acknowledge and understand that during the course of the procedures described in paragraph (A), conditions may develop which may reasonable necessitate an extension of the original procedures or the performance of procedures which are unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons described in the last paragraph of this consent to make the decisions concerning the performance of and to perform such procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

B. (1) I acknowledge and understand and duly evidence in writing by executing this form that I have been informed in general terms of the following:

−1− A diagnosis of the condition requiring the procedures;
−2− The nature and purpose of the procedures;
−3− The material risks of the procedures (see paragraph (A) above);
−4− The likelihood of success of the procedures;
−5− The practical alternatives to such procedures; and
−6− The prognosis if the procedures are rejected;

and that such was provided through the use of video tapes, audio tapes, pamphlets, booklets, or other means of communication or through conversations with the responsible physician, or medical personnel under the supervision or control of the responsible physician, other medical personnel involved in the course of treatment, nurses, physician assistants, trained counselors, or patient educators.

C. ** (1) I acknowledge and understand that in addition to the material risks of the procedures listed in paragraph (A) above there may be other risks attendant to the performance of the procedures as there are with any surgical or diagnostic procedure.

D. ** (1) I acknowledge that there are practical alternatives to the procedures described in paragraph (A) which alternatives reasonably prudent Physicians generally recognize and accept.

E. ** (1) I acknowledge and understand that the physician, medical personnel, and other assistants will rely on the patient's statements, medical history, and other information provided by the patient in determining whether to perform the procedures or the course of treatment for the patient's condition and in recommending the procedures which have been explained

F. ** (1) I acknowledge and understand the practice of medicine is not an exact science; and I acknowledge that NO GUARANTEES HAVE BEEN MADE TO ME concerning the results of the procedures.

G. ** (1) I also consent to diagnostic studies, tests, anesthesia, x−ray examinations, and any other treatment or courses of treatment relating to the procedure described in paragraph (A) which may be prescribed or ordered.

H. ** (1) I also consent that any tissues, specimens, members, etc removed in the course of any procedure may be tested, retained, or preserved for Scientific or teaching purposes and then disposed of within the discretion of the physician, facility, or other health care provider.

COFFEE REGIONAL MEDICAL CENTER

CONSENT TO SURGICAL OR DIAGNOSTIC PROCEDURES

I. ** (1) I acknowledge and understand that this request for and consent to surgical or diagnostic services shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.

J. ** (1) **I acknowledge that some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.**

I acknowledge and understand that as appropriate and as determined by the physician, the presence of outside personnel such as: a vendor/manufacturer representative if an implantable device is used, and if a device is used, the representative will assist in the selection and calibration of the equipment and/or device(s) and in the related treatment, and an assistant to the representative. In addition to such outside personnel, there may be an intern; resident; and/or student present in the room to assist and/or observe in the procedure as described above. What these outside personnel are allowed to do will depend upon their skill and the Patient's condition as assessed and determined by the Physician. It is understood that these additional personnel will be under the supervision and direction of the Physician.

I further acknowledge and understand that the physician, at his discretion, may utilize First Assistants, Advanced Practice Nurses, and/or Physician Assistants to perform certain tasks as directed by the Physician during the procedure. These tasks may include skin closure, but it is not limited to this task as the task depends on the procedure and need at the time. What these non−physician medical personnel are allowed to do will depend upon their skill and the Patient's condition as assessed and determined by the Physician. They will be under the supervision and the direction of the Physician.

I HAVE BEEN GIVEN SUFFICIENT OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. ** *ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION, INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATING TO THE PROCEDURES DESCRIBED HEREIN.*

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW DR. _____ OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFORMING SUCH PROCEDURES TO PERFORM THE PROCEDURES DESCRIBED OR OTHERWISE REFERRED TO HEREIN.

Witness Signature	Date	Time
Signature of Patient or Other Person Authorized to Sign	Date	Time

I HAVE DISCUSSED THE RISKS, BENEFITS AND ALTERNATIVES OF THE PROCEDURE WITH THE PATIENT.

Physician's Signature	Date	Time

Additional materials used, if any, during informed consent process for this procedure include: _____

Person giving consent: _____

LAST, FIRST MNAME ROOM−BED s
V1234 t 04/30/2008 M1234 **m**
04/30/2008 *00M 07D*