CONSENT FOR PROCEDURE
(Evidence of informed consent)

I, _____ (patient name) consent to allow

_____ and their associates, assistants, and appropriate

healthcare providers to perform the following procedure(s): _____

_____

_____

Name of surgery or procedure in medical words – including any laterality or level.

1. The risks, benefits, and possible problems, which may include infection, bleeding, blood vessel and/or nerve injury, injury to other tissue and/or organs affected by the process of my intended procedure, brain, spine or other nervous system damage, loss of use of body parts and/or life have been explained to me.
2. Other options to the procedure, as well as the possible benefits and the likelihood of achieving the goals of the proposed procedure have also been explained. My doctor has discussed with me the possible problems with recovery and outcomes I may or may not expect as a result of the procedure. My doctor has also explained the risks, benefits, and possible results of not having the procedure. No guarantee of success or cure has been given to me.
3. I understand that during the procedure, unforeseen conditions may necessitate additional or different procedures. I authorize my doctor and their associates, assistants, and appropriate healthcare providers permission for such procedures to be performed.
4. If deemed necessary by my doctor, I agree to receive blood/blood products (The "Blood and/or Blood Products Consent or Refusal Form" is required when blood is refused.)
    a. ☐ Refusal of blood signed on the "Blood and/or Blood Products Consent or Refusal Form."
5. I understand the physician, anesthesiologist, and their assistants may not be employees of the hospital.
6. I understand any positive infectious disease results may be reported to the local county health department per state law.
7. I agree to allow the hospital to dispose of any removed tissue, body parts, organs, or devices/implants as consistent with facility policy and state and federal regulations.
8. I understand that photographs and/or videos of my procedure may be taken for scientific/teaching and treatment purposes as long as my identity is not revealed. I consent to the taking of these photographs and/or videos in accordance with appropriate BayCare policy.
9. I understand the facility may allow individuals to be present during my procedure who are not directly involved in the procedure. I consent to their presence during the procedure in accordance with appropriate BayCare policy.
10. I understand I have the right to refuse any medical/surgical procedures. I certify that I have read this consent or have had it read to me in a language I understand; that I have had an opportunity to ask questions; that all my questions have been answered to my satisfaction; and that I knowingly and willingly give consent to have this procedure/treatment. This consent was given freely and voluntarily.

_____	_____	_____	_____
Signature of patient or other legally authorized person	Date/Time	Relationship to the patient, if not patient	Reason for signature other than patient
_____	_____	_____	_____
Witness	Date/Time	Second Witness (Telephone consent)	Date/Time

I have explained the procedure(s), including risks, benefits, and alternatives to my patient/other legally authorized person.

_____	_____	_____
Physician/Provider Signature	MS#	Date/Time