



### INFORMED CONSENT FOR MEDICAL AND/OR SURGICAL TREATMENT

**I understand that I have the option to disagree with any statement below. To indicate that I will draw a line through the words, write the word "no" and the date, time, along with my initials.**

1. I agree to have \_\_\_\_\_ ("Physician/Practitioner") and any Associates or Assistants  
(Physician/Practitioner first/last name)  
selected by the Physician/Practitioner perform the following operation(s) or procedure(s) (The "Procedure") on me or the patient named above:

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2. I consent to the administration of such sedation/anesthetics as are necessary or appropriate for the Procedure. If procedural sedation is administered, I understand it is *given* to keep me comfortable during the Procedure. A nurse or other qualified personnel will administer the procedural sedation. I understand that amnesia of variable duration is a probable and often desirable consequence of sedation/anesthesia, however amnesia cannot be guaranteed. I understand that possible complications of sedation/anesthesia may include difficulty breathing, low blood oxygen levels, low or high blood pressure, heart rhythm disturbance, prolonged sedation or allergic reaction. I have been fully informed of the risks and possible complications of procedural sedation, and/or anesthesia, and have been given the opportunity to ask questions.

3. I agree to have additional procedures performed on me during the Procedure if my Physician/Practitioner decides they are needed or appropriate for reasons not known before the Procedure.

4. I also authorize my Physician/Practitioner to provide or arrange for the provision of additional services during the Procedure, as necessary or advisable by my Physician/Practitioner, including but not limited to, pathology, radiology, diagnostic and therapeutic services.

5. Administration of Blood and/or Blood Products: I consent to the administration of blood and/or blood products during my **surgery and post-surgery** hospitalization **if deemed necessary** even if not anticipated, to be administered as determined by my physician. I have been informed of and understand the risks, benefits, and alternatives to the administration of blood and/or blood products.

\_\_\_\_\_ I **Do NOT** consent to the administration of blood and/or blood products  
(Initials)

6. If I have requested not to be resuscitated, I understand that this decision may require a discussion between me and the physician(s) responsible for my care. At my or my legal representative's request, a Do Not Resuscitate order may remain in effect during the diagnostic or therapeutic procedure.

7. All procedures have risks, including bleeding, infection, serious injury and even death. I have been informed of the nature of the Procedure, the potential benefits, side effects and risks (including those identified above and the following specific risks, if applicable, \_\_\_\_\_

\_\_\_\_\_  
(if none leave blank or specify risks)

of the Procedure, and problems that may occur during recovery. I have also been informed of the reasonable alternatives to the Procedure (including the possibility of not performing the Procedure) and the risks and benefits of such alternatives and the likelihood of achieving my goals. If applicable, my Physician/Practitioner has discussed the implant planned and implant type to be used. I understand that the explanations I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved. However, I agree that the information that I have received is sufficient for me to consent to the Procedure.



