MADISON Surgery Center at 1 SOUTH PARK

PATIENT LABEL

Date:_____

STATEMENT OF CONSENT:

CONSENT TO OPERATIONS, ANESTHETICS DIAGNOSTIC RADIOLOGY, TRANSFUSION, OR OTHER PROCEDURES

I request and authorize Dr. _____, and/or other doctors, assistants, students, and staff who may be assigned to my care, to perform on: _____
(Patient's Name or "Myself")

the following operation(s) or procedure(s): _____

_____

_____

_____

(DO NOT ABBREVIATE)

When the procedure is planned for one side of the body, indicate the planned side here: ❑ RIGHT ❑ LEFT

I have read the **reverse side of this form** and have crossed out, limited, or made the following changes:

_____

A copy of this form will be used as authorization for **blood products and other services.**

By signing below, I acknowledge (1) that I have read **BOTH SIDES OF THIS FORM**, (2) that I understand the form and information provided by my doctor or doctor's designee, (3) that I have had the opportunity to ask questions and have had them answered to my satisfaction, and (4) that I hereby give authorization and consent to the performance of the operation(s) or procedure(s) listed above. The risks and benefits of, and viable alternatives to, the operation(s) or procedure(s) have been explained to me and I agree to proceed.

AUTHORIZING SIGNATURES:

Signature of Patient or Person Authorized to Sign	Physician Signature
Print Name	Print Physician Name
Relationship to Patient	
Date Time AM PM	Date Time AM PM

Witness Signature*

Print Witness Name

Date Time AM PM

Interpreter or Reader Signature (if applicable)

Print Interpreter or Reader Name

Date Time AM PM

* Only required if patient signature not obtained by physician or when telephone consent obtained.

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I understand:

1. A physician has explained to me the nature, purpose, and risks of the proposed procedure(s) needed to diagnose or treat my condition(s). I have further had explained to me and discussed available alternative methods of treatment, including their risks, consequences, and probable effectiveness. I have also been informed of the possible results should this procedure not be performed. I understand the risk of complications, serious injury or even death that may result from both known and unknown causes. I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest (heart attack), etc., that can occur in the performance of any procedure.

2. I have also had it explained to me that before, during, or after the procedure listed above, I may develop or the physician may discover new conditions which the physician could not foresee. These new conditions might make it necessary or advisable for additional or different procedures to be used in my diagnosis and treatment. I therefore request and authorize my doctors to use such additional or different procedures as they think necessary or advisable for my diagnosis or treatment.

3. I have been informed that an anesthetic may be administrated to me by a member of the Department of Anesthesiology (i.e. physician only, a physician supervised resident or a nurse anesthetist) for general, regional, or monitored anesthesia. For a local or conscious sedation procedure, the operating room surgeon directs a conscious sedation nurse. The alternatives and usual risks and benefits associated with its administration have been explained to me. I consent to the administration of such anesthesia. Restrictions, if any, on the type of anesthetic are described on the description of the procedure.

4. I agree to receive blood or blood products if deemed necessary by my physician(s). The benefits, risks and alternatives associated with blood product use have been explained to me, as well as the risks of refusing blood products. I understand that the blood products have been tested for hepatitis, HIV/AIDS, and some other pathogens. Blood products may or may not have been tested for bacteria and other pathogens including West Nile Virus. Testing greatly reduces, but does not eliminate, the possibility that you (the patient) may get these or other infections from the blood. Other occasional complications include allergic reactions such as hives, chills, fever and nausea. Other infrequent complications include rapid destruction of transfused blood, fluid excess in the lung, shock and severe allergic reactions. I understand that when my (the patient's) medical condition permits, I (the patient) may donate his/her own blood in advance for later transfusion. I understand that such blood donations are not free from risk and may not satisfy all blood requirements.

5. I understand that it is the practice of this surgery center and the physicians providing my care to temporarily suspend “do not resuscitate” (DNR) orders and I agree to such suspension. DNR orders may remain in effect during operations only with the written agreement of the surgeon and anesthesiologist.

6. The independent practitioners who have been granted privilege of using this facility for the care and treatment of patients are not employees or agents of the surgery center. The University of Wisconsin Hospitals and Clinics and its medical staff have service, educational, and research relationships with the University of Wisconsin Madison and other affiliated health care, service and educational institutions. The physicians involved in the care are comprised of medical staff members on the University faculty, residents or fellows in training programs.

7. I also have been informed and understand that the practice of medicine, surgery and dentistry is not an exact science. No guarantees or promises have been made to me concerning the results of the procedure(s).

8. I consent to the observing, photographing, filming, televising, or recording of any of the procedure(s) to be performed for purposes of performance improvement, helping medical education or helping medical knowledge. I understand that my identity will not be made known by the pictures.

9. Any tissue, fluids or body parts removed during the procedure(s) may be disposed of or retained. I also consent to use of such tissue, fluids or body parts for research, except as noted here: _____.

10. I have been informed that there may be a need to disclose or report information about me (the patient) under certain circumstances such as reporting cases of HIV, tuberculosis, and other diseases to organizations such as the state health department.

_____
Patient Initials