Patient Name:_____ Date of Birth: _____/_____/_____

Washington State law guarantees that you have both the *right* and *obligation* to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. **CONDITION:** I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by said physician to treat the following condition(s) which has (have) been explained to me: *(Explain the nature of the condition(s) in professional and lay language.)*

2. **PROCEDURE:** The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand the nature and character, anticipated results and benefits, and possible alternative forms of treatment to be: *(Describe procedures, treatments, and anticipated results in professional and lay language. Also list important aspects or significant surgical tasks to be performed by an associate/assistant.)*

3. I recognize that, during the course of the operation, postoperative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those above set forth. **I therefore authorize my above named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her or their professional judgement necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of **all conditions** that require treatment and are not known to my physician at the time the medical or surgical procedure commenced.

4. **I have been informed that there are significant risks** such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. **I acknowledge that no warranty or guarantee has been made to me as to result or cure.**

*Any sections below which do not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by **both** physician **and** patient.*

5. I consent to the administration of anesthesia by my attending physician, by an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver and kidney and that in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

6. I consent to the use of transfusion of blood and blood products as deemed necessary. I understand that all blood products involve risk of allergic reaction, fever, hives, and in rare circumstances infectious diseases such as Hepatitis & HIV/AIDS. I understand that precautions are taken by the blood bank in screening donors and in matching blood for transfusion to minimize those risks.

7. Any tissues or parts surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

8. In the course of the procedure I understand technology may involve imaging of the site to include photography and video. If so, this may become a part of my medical record and would be offered the same protections from disclosure.

9. I hereby authorize and consent to the presence of observers and/or video imaging of the procedure(s). Observers may include students, visiting RNs/MDs, product vendors and/or members of the hospital administrative staff. They have no role or responsibility in performing the procedure(s).

PHYSICIAN'S STATEMENT

The medical procedure or surgery stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results, was explained by me to the patient or his/her representative before the patient or his/her representative consented.

Physician Signature _____ Date: _____ Time: _____

PATIENT OR PATIENT REPRESENTATIVE'S ACKNOWLEDGEMENT

Patient or Patient's Representative should indicate his/her decision to receive full or limited disclosure by initialing the appropriate line below.

_____ **FULL DISCLOSURE**: I certify that my physician has informed me of the nature and character of the medical procedure or surgery described on this form, including its possible significant risks, complications and anticipated results, and the alternative forms of treatment, including non-treatment, and their significant risks, complications and anticipated results.

_____ **OR LIMITED DISCLOSURE:** Upon specific request by the patient they do not wish to have risks and facts explained to them.

I acknowledge that I have read (or have had read to me) and fully understand the above consent, the explanations referred to were made, and all blanks requiring insertion or completion were filled in before I voluntarily affixed my signature.

Signature of Patient or Patient's Authorized Representative / Relationship: _____ Date: _____ Time: _____

WITNESS ACKNOWLEDGEMENT

Witness Signature / Print Name: _____ Date: _____ Time: _____

GRAYS HARBOR COMMUNITY HOSPITAL

M.SURCONST

Special Consent to Operation, Post Operative Care, Medical Treatment, Anesthesia, or Other Procedure

NU872-039 (12/13)

PATIENT LABEL

CHART