Bethesda Hospital East

2815 S. Seacrest Blvd
Boynton Beach, FL 33435
(561) 737-7733

Bethesda Hospital West

9655 Boynton Beach Blvd
Boynton Beach, FL 33472
(561) 336-7000

PATIENT:

I hereby authorize Doctor(s)

to perform upon

the following procedure or operation:

PATIENT - PLEASE INITIAL the lines next to each paragraph of this consent to indicate your agreement with the statements therein.

	The physician has explained to me the nature of this operation and how it is carried out. I understand that all surgeries and procedures involve general risks such as severe loss of blood, infection, heart stoppage, and in rare cases death. The physician has discussed with me the specific risks, benefits and possible side effects of this procedure and I understand them.
	In addition, the physician has explained to me that there are alternative ways of treating my condition but I have chosen this procedure.
	I consent to the administration of sedation with or without anesthesia by or under the direction of above physician and to the use of such medications as may be deemed advisable. When an anesthesiologist or nurse anesthetist is involved, an evaluation will be performed by them and the administration of sedation will be directed by them. I consent to the administration of blood and blood products, to the disposal by authorities of Bethesda Memorial Hospital of any tissue or parts which may be removed; to the taking and publication of photographs or video taping in the course of operation; and to the admittance of observers to the procedure room for the purpose of advancement of medical education.
	I permit and authorize the physician and such other physicians or qualified medical persons as are needed to perform this operation on me.
	The physician has explained to me that sometimes during surgery, it is discovered that additional surgery is needed. If such additional surgery is deemed necessary by the physician, I permit the physician to proceed.

Patient Name:		Patient#:	
MR#:		Attending physician:	
Admission Date:		DOB:	
Gender:		Age:	

I understand that no guarantees have been made to me that this operation will improve my condition.

Name: Date: Time:

(PATIENT SIGNATURE)

Patient is unable to sign because:

Name: Date: Time:

(If patient unable to sign, person authorized to sign.)

Name: Date: Time:

(Witness to Signature or Telephone Consent Only)

Name: Date: Time:

(Second Witness to Telephone Consent Only)

Interpreted By:

Date: Time:

(Interpreted By)

Patient Name:		Patient#:	
MR#:		Attending physician:	
Admission Date:		DOB:	
Gender:		Age:	