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

CONSENT TO DIAGNOSTIC PROCEDURE OR OPERATION

PATIENT:

I here by authorize Doctor(s) to perform upon the following procedure or operation:

The Physician has explained to me the nature of this operation it is generally carried out. I understand that all procedures surgeries involve general risks such as severe loss of blood, infection, heart stoppage or 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 anesthesia by or under the direction of a fully qualified anesthestist and to the use of such anesthetics as may be deemed advisable. 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 operating room for the purpose of advancement and medical education.

I permit and authorize the physician and such other physicians qualifeid 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.

Bethesda Memorial Hospital

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

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

_____
(PATIENT SIGNATURE) _____ Date:_____ Time:____

Patient is unable to sign because:

_____
(If patient unable to sign, person authorized to sign.) _____ Date:_____ Time:___

_____
(Witness to Signature or Telephone Consent Only) _____ Date:_____ Time:___

_____
(Second Witness to Telephone Consent Only) _____ Date:_____ Time:___

Interpreted By:

(Interpreted By) _____ Date:_____ Time:____

FORM:	**Surgical Consent Form**	**MRIN#:**	
PATIENT:		**DOB:**	
PATIENT#:		**AGE:**	
GENDER:		**DATE:**	
ADMIT DATE:		**TIME:**	