EMORY
HEALTHCARE

Consent to Surgical or Medical Treatment

Diagnosis: _____

_____

Name of Procedure: _____

_____

1. I understand the following about the procedure named above: _____

   _____

   a. **Nature and purpose of procedure** *(Describe in laymen's terms)*:

      _____

      _____

   b. **Material risks of procedure: DEATH, RESPIRATORY ARREST, CARDIAC ARREST, BRAIN DAMAGE, DISFIGURING SCAR, PARAPLEGIA OR QUADRIPLEGIA, PARALYSIS OR PARTIAL PARALYSIS, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, SEVERE LOSS OF BLOOD, ALLERGIC REACTION AND INFECTION.** These are material risks of any surgical procedure. Other risks and/or the potential side effects of this procedure are:

      _____

      _____

      _____

   c. **Likelihood of success:** ❑ Good ❑ Fair ❑ Poor
      ❑ Unknown because: _____

      _____

   d. **Practical alternatives to procedure:**

      _____

      _____

      _____

   e. **Prognosis if procedure rejected:** ❑ Good ❑ Fair ❑ Poor
      ❑ Unknown because: _____

      _____

   f. ❑ **If applicable, DNR Order or DNI/Special Code status suspended unless indicated otherwise:**

      _____

      _____

      _____

2. The nature and purpose of the procedure identified above have been explained to me, including the potential benefits and side effects of the procedure. I understand the practical alternatives to the procedure and their risks and I hereby consent to the performance of this procedure by Dr. _____ and/or any assistants whom may be present. I also consent to the administration of anesthesia to be applied by or under the direction and supervision of the Section of Anesthesiology of the Emory Clinic.

3. I realize that, during the procedure, the physician/surgeon may become aware of conditions which were not apparent before the start of the procedure, or may determine that additional or different operations or procedures are necessary or appropriate. I therefore authorize and request that the above named physician/surgeon and/or any assistants whom may be present to perform additional or different operations or procedures the physician/surgeon deems necessary or advisable; so long as these additional procedures do not conflict with my stated DNR or DNI/Special Code preferences as indicated above.

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4. I acknowledge and agree that any tissue, organ, specimen, member or implant, removed or severed from my body during the procedure described above may be retained, preserved, analyzed, disposed of, or otherwise used for any lawful purpose, including medical education and teaching, by the Emory University Hospitals or the Section of Pathology of The Emory Clinic at the discretion of the Hospitals or Section, except for the following: _____
_____
5. I acknowledge that the physician/surgeon, or his/her designee, may photograph, videotape or otherwise make recordings of me or my image before, during, or after this procedure for purposes related to care, treatment and/or medical education.
6. I understand that this consent form will be valid for 30 days, unless I have signed this consent in conjunction with an admission to the hospital, in which case this consent will be valid for 30 days from the date of admission or for the duration of my hospitalization, whichever is greater.
7. I acknowledge that no guarantees have been made concerning the outcome of the surgical or medical treatment, and I realize that the practice of medicine and surgery is not an exact science. I have read all of the above information, and I have been given the chance to ask any questions, and all of my questions have been answered to my satisfaction.

I REQUEST AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE AS OUTLINED ABOVE.

_____ _____ _____ _____
Signature of Patient/Authorized Representative | Date | Time | If not patient, relationship to patient

Printed Name of Patient/Authorized Representative (print) _____
☐ Check if telephone consent given

Witness to Signature:_____ Date: _____ Time: _____
(Every effort should be made to obtain a witness signature)

Interpreter Name/Operator Number:_____

Signature of Person Obtaining Consent:_____ Date: _____ Time: _____

For Medical Device Recipients Only

Under Federal law, a hospital must report patient information to a company which manufactures medical devices, under some circumstances, including product recalls. However, the hospital can report your social security number to a manufacturer only with your permission. Your social security number may help the manufacturer identify you in the rare case of a product recall. I ☐ do ☐ do not authorize the hospital to report my social security number to the manufacturer of the medical device I receive.

Additional Authorizations for Surgical or Medical Treatment

The purpose of this section is to authorize repeat identical operations/procedures which have already been explained on the reverse side. If there is any change in the operation or other procedure to be done or in the associated risks, another "Consent to Surgical or Medical Treatment" form is to be completed.

Surgical or Medical Treatment	Patient/Person authorized to consent for patient	Date and Time