1. I hereby authorize ___________________________ and ___________________________ and those associates

or assistants designated to perform upon ___________________________ the following treatments, surgeries, procedures

(referred to as "Procedure") to include: ________________________________________________________________

A team of medical professionals will work together to perform my Procedure. My Attending Physician/Privileged Provider, or other Designated Privileged Provider, will be present for all critical parts of the Procedure. I understand that other medical professionals may perform some parts of the Procedure as my doctor or the Designated Privileged Provider deems appropriate.

2. The Attending Physician/Privileged Provider above (or their designee, if n/a leave blank: ___________________________) has fully explained to me, in my preferred language what will happen during and after my care, including any additional Procedures, and/or medications I will receive, including during my recovery. They have also discussed the potential risks, benefits, and alternatives of this care. I further understand that images or sound recordings may be taken or organs, tissues, implants, or body fluids may be removed, examined, and retained for the purposes of medical care and safety improvements. If these are disposed of, it will be done according to our usual practices. I also agree to allow the presence of necessary technical or vendor support persons into the Procedure room for the purposes of my medical care. I have been informed of the likelihood of achieving the proposed goals and the reasonable alternatives to the proposed plan of care including not receiving the proposed treatments. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.

3. I understand that during the course of the above proposed Procedure something unexpected may come up and I may need a different Procedure. I consent to the additional Procedure which the above-named physician or their Associates/Assistants/Designated Privileged Providers may consider necessary.

4. I understand that my medical professional may provide me with medications to keep me comfortable and safe such as anesthetics/sedatives/analgesics. I understand that my medical professional has or will speak to me about the risks, benefits, and alternatives to these medicines before my treatment.

5. If applicable, I agree that I may need blood or blood product transfusions as part of my medical treatment. I agree that my medical professional has spoken to me about the risks, benefits, and alternatives to receiving blood and blood products.

☐ I decline the above regarding blood or blood product transfusions.

6. If applicable, I agree that organs, tissues, implants, or other body fluids may be removed, examined, and kept for scientific or educational purposes.

☐ I decline the above regarding organs, tissue, implants, and body fluids for scientific or educational purposes.

7. If applicable, I agree to allow the recording of images and sound of this Procedure for educational purposes such as presentations and publications.

☐ I decline the above regarding pictures and sound recordings for educational purposes.

8. If applicable, I agree to allow authorized observers into the operating or treatment room.

☐ I decline the above regarding observers.

9. I have marked the portions of the document I do not agree to.

☐ Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative***/Interpreter signature not required.

► The Attending Physician or Privileged Provider who is performing the procedure must sign the certification below.

I, the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have been explained to the patient/guardian/representative** and I have offered to answer any questions and have fully answered all such questions. I believe that the patient/guardian/representative** fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

__________________________

Print name

Attending Physician/Privileged Provider Signature

Date

Time

► If more than thirty days have passed since this consent form was signed or the consent conversation was held:

I, the Attending Physician or Privileged Provider, have reaffirmed the patient/guardian/representative’s** understanding and certify that there has been no substantial change to the patient’s condition in the time period since the consent form was signed.

__________________________

Print name

Attending Physician/Privileged Provider Signature

Date

Time

* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.

** Throughout this document, the term “representative” refers to a legally authorized representative.

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT’S MEDICAL RECORD.
1. Mwen otorize:

Doktè responsab la/pwofesyonèl swen sante privileyiye
oswa asistan yo chwazi yo pou yo egzekte sou
APRE "Pwosedì"

2. Doktè responsab la oswa pwofesyonèl swen sante privileyiye ki anlé a (oswa reprezentan yo, si pa genyen kite l blanc):

3. Mwen konprann pandan pwosedì ki pwopozite anle an ap fèt kapab gen yon bagay yo.

4. Mwen konprann pwofesyonèl medikal mwen an kapab medikaman ki pou ebe m rete konfòtab ak an sekkirite tankou anestezii/sedativ/analjezik.

5. Si aplikab, mwen daò mwen kapab bezwen pran san oswa pwodui san ki ka fe pé fòti tretman mwen an.

6. Si sa aplikab, mwen daò pran san oswa pwodui san.

7. Si aplikab, mwen aksepte bay pèmisyon pou anrejistre son ak imaj Pwosedì sa a pou edikasyon tankou prezantasyon ak piblikisyen.

8. Si aplikab, mwen te pale ak mwen sou risk, avantaj chwa ki genyen pou resevwa tretman yo.

9. Mwen te make pati nan dokiman mwen pa daò yo.

**Konsantman Téléfon/Videyo (Koche ka si sa aplikab), Siyati Pasyan/Responsab Legal**/Reprezantan pa obligatwa.

The Attending Physician or Privileged Provider who is performing the procedure must sign the certification below.

I, the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have been explained to the patient/guardian/representative** and I have offered to answer any questions and have fully answered all such questions. I believe that the patient/guardian/representative** fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

**If more than thirty days have passed since this consent form was signed or the consent conversation was held:**

I, the Attending Physician or Privileged Provider, have reaffirmed the patient/guardian/representative's** understanding and certify that there has been no substantial change to the patient's condition in the time period since the consent form was signed.