



015600.0703

MR#

LW Acct#

Name

PROCEDURE CONSENT FORM

Complete or Imprint with Address-O-Plate

1. I hereby authorize Dr.(s) _____ to perform upon
(Patient Name) _____ the following surgical and/or medical
procedures: (State specific nature of the procedure(s) to be performed)

2. I authorize the following device(s) to be implanted during the above-named procedure:
(type of device/implant)

3. I understand that the procedure(s) will be performed at Thomas Jefferson University Hospital or its Methodist Hospital Division by or under the supervision of the attending physician. He/She is authorized to utilize the services of such other health care professionals and trainees including physicians, and members of the house staff as he/she deems necessary or advisable in the performance of the procedure(s) listed above. I understand that in certain circumstances it may be necessary for a health care industry representative to be present in the operating room to consult with the operative team.

4. I understand that Thomas Jefferson University Hospital is an academic medical center and that students and trainees will be participating in my care, under appropriate supervision.

5. I understand that during the course of the surgical procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedures than those set forth in Paragraph one. I authorize and request that the above-named surgeon, his/her assistants, or his/her designees perform such surgical procedure(s) as are necessary and desirable in the exercise of their professional judgment.

6. I acknowledge that the available anesthesia options have been explained to me along with the benefits and attendant risks. I consent to the administration of the following type of anesthesia/sedation to be applied by or under the direction of my physician:

Moderate Sedation ("Conscious Sedation")

Local Anesthesia

7. A physician member of the Anesthesiology Department will obtain consent for any additional anesthesia required. I understand that during the course of the surgical procedure, unforeseen changes in my condition may arise which may necessitate a change in the care being provided to me. Should such an instance arise, I permit the anesthesiologist to provide treatment, which he/she deems necessary for my safety and well being.

8. Dr. _____ has fully explained to me the nature and the purpose of the procedure(s), the benefits, possible alternative methods of diagnosis or treatment, the risks involved, the possibility of complications, the foreseeable consequences of the procedure(s) and the possible results of non-treatment. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

Patient Name _____ MR# _____

9. I understand that if it is necessary for me to receive a blood transfusion and/or human source product (including, but not limited to bone, tissue, tendon, bone graft, etc.), the blood and/or product will be supplied by sources available to the hospital and tested in accordance with national and regional regulations. I understand the benefits of receiving a blood transfusion and/or human source product. I also understand that there are risks associated with the transfusion of blood and/or the use of human source products, including but not limited to allergic, febrile and hemolytic transfusion reactions, and transmission of infectious diseases such as Hepatitis and AIDS (Acquired Immune Deficiency Syndrome).

10. I understand the alternatives to transfusion such as autologous donation (donation of the patient's own blood), directed donation (donation on behalf of the patient by friends and relatives) and intra-operative salvage (use of the patient's own blood recovered during the procedure if the condition, time and the surgical procedure allow). I understand that these options, by themselves, may not be sufficient to preserve my life.

11. I hereby consent to the transfusion of blood components and/or the use of human source products, and agree to hold harmless the hospital, its physicians, and all members of its staff from any liability resulting from the administration of blood and/or human source products.

I refuse the transfusion of all blood components and/or human source products and have signed the Form to Refuse the Transfusion of Blood and/or Human Source Products.

12. I hereby allow authorized representatives from Thomas Jefferson University Hospital and its Methodist Hospital Division to examine or photograph portions of my body, use dismembered tissue for education, medical research or development purpose(s), and dispose of tissue which may be removed, as necessary for my diagnosis/treatment.

13. I certify that I have read and fully understand the above consent statement. In addition, I have been afforded an opportunity to ask whatever questions I might have regarding the procedure(s) to be performed and they have been answered to my satisfaction.

14. I have been informed of the identity and professional status of other individuals who will be assisting in the procedures and/or treatments, and have had the opportunity to ask questions regarding the professional, educational and business relationships my physician may have with other health care providers and/or institutions.

Patient/Authorized Representative Date _____ Time _____ am/pm
(State relationship to patient)

Witness Signature Date _____ Time _____ am/pm

I certify that I have explained the risks, benefits and alternative of this treatment to the patient or his/her surrogate, and have answered all of his/her questions.

Physician Signature Date _____ Time _____ am/pm