



MOUNT AUBURN  
HOSPITAL

### Consent for Medical Surgical and/or Diagnostic Procedures

To The Patient: You have been given information about your condition and the recommended surgical and/or invasive procedure(s). This form is designed to provide a written confirmation of such discussion by recording some of the more significant medical information given to you. It is intended to make you better informed.

1. I give my permission to Dr(s) \_\_\_\_\_

To perform the following procedure(s)/operations(s): \_\_\_\_\_

\_\_\_\_\_

2. I understand that during this procedure(s)/operation(s), new findings or conditions may appear and require an additional procedure(s)/operations(s) for proper treatment of my case, including blood transfusions that my doctors feel are necessary or advisable.

3. Blood transfusions are often required during my type of procedure and I understand that there are risks associated with the transfusion of blood or blood products even when all precautions are taken. I have reviewed the "Patient Information Sheet: Blood Transfusion" and I authorize the transfusion(s) my physician feels are necessary.  Yes  N/A

4. My doctor has talked to me about my condition and has informed me what is going to be done. I have been told about the possible risks and complications and the chances of success. These risks may include such things as allergic reactions, bleeding, blood clots, infection, nerve injury, brain damage, and loss of bodily function or life. I realize that other risks may occur in connection with the procedure(s) proposed to me:

\_\_\_\_\_

5. We have discussed what could happen if nothing is done and what else might be done to treat my condition. I know that other unexpected risks or complications not discussed may occur and that there is no guarantee about the results of the procedure(s)/operation(s).

6. I know that Resident Doctors and other clinical students/staff may help my doctor during my procedure(s)/operation(s) and during my hospital stay. I understand that an Equipment Representative may be present in the room to serve as a technical resource to facilitate the use of equipment, however, will not directly participate/assist my doctor during the procedure(s)/operation(s).

7. As part of my procedure, I understand that I may be given conscious sedation during my procedure(s)/treatment(s). I further understand, that while I will remain conscious, there are risks as with any procedure. At times, even with conscious sedation, it may be necessary to ventilate the lungs of the patient. Additional risks of lung ventilation, which requires the placement of a breathing tube, could include: injury to teeth, damage to vocal cords, respiratory problems, and minor pain and discomfort. I understand the risks and benefits of conscious sedation and consent to its administration.

8. Removal of all body piercing has been recommended and I have been informed of the risks of burns.

9. I understand what my doctor has said and have had all my questions fully answered.

10. Having talked with my doctor and having had the opportunity to read this form, my signature below acknowledges that I consent to the performance of the procedure(s)/operation(s) described above.

\_\_\_\_\_  
Patient (or person authorized to sign)

\_\_\_\_\_  
Physician/Surgeon

\_\_\_\_\_  
Date