CONSENT FOR OPERATION / PROCEDURE

I, the undersigned, a patient in Southern Ohio Medical Center Hospital, hereby authorize _____ and whomever he or she may designate as assistants, to administer such treatment as is necessary to perform the following operation(s) / procedure(s):

_____

_____

_____

and such additional operations as are considered therapeutically necessary on the basis of findings during the course of said operation. I also consent to the administration of such anesthetics as are necessary by a qualified member of the hospital's anesthesia group and to the use of such anesthetics as he or she may deem advisable. I consent that any tissue or parts surgically removed may be disposed of by the Hospital in accordance with accustomed practice. I hereby appoint a hospital designee the authorizing agent for the purpose of cremation in such case. I understand that Southern Ohio Medical Center is a teaching hospital for training of healthcare providers. I hereby consent to the participation in my care by appropriate healthcare provider students under the supervision of appropriately qualified physicians, nurses or other hospital employees. A Health Care Industry partner may be present at the request or preference of the surgeon. I have read and fully understand this authorization for medical and surgical treatment. The nature and purpose of the surgery, treatment or procedure and the (1) advantages, (2) possible complications, including those that could arise from the use of anesthesia and the potential interactions with alcohol, drugs, illegal substances, and/or herbs, (3) possible alternative modes of treatment have been fully explained to me.

My provider and I have discussed the potential for blood transfusion related to this procedure. I understand risks, benefits, possible alternatives, and complications associated with transfusion. All my questions about blood products administration have been answered. These risks and complications include a reaction to the blood and the transmission of infectious diseases including viral hepatitis and AIDS. I release the hospital, personnel, and the attending provider from any responsibility whatever for unfavorable reactions of blood products administration or untoward results due to my refusal of blood products.

I authorize the use of blood and/or blood products, should they be deemed necessary by my provider, from the period of hospital arrival through hospital discharge.

- ☐ I agree to accept blood products
- ☐ I refuse the administration of blood and all blood products and understand that there is a risk that I may become seriously ill or die if I choose to not accept any type of blood donation.

I am aware that the practice of medicine and surgery is not an exact science and I certify that no guarantees have been made to me as the result of treatment or examination and that all blanks or statements of the within consent requiring insertion, completion or deletion were filled in or stricken out before I affixed my signature below.

I understand that should I have an 'Advanced Directive' and/or existing orders specifying or limiting resuscitative efforts, that these directives will be suspended until I have fully recovered from the use of anesthetics.

I authorize the surgeon, in his/her discretion, to video my operation and, if done, to maintain possession of the video as long as he/she deems advisable.

Patient:	SIGN:	DATE:	TIME:
Witness:	SIGN:	DATE:	TIME:

(Witnessing the consent being signed is all the witness is attesting to as he or she may not have been present during the informed consent discussion.)

Person Authorized to Consent for Patient: _____ Date/Time: _____

Relationship to Patient: _____

AFFIRMATION OF INFORMED CONSENT BY ATTENDING PHYSICIAN / PROVIDER PROVIDING SERVICE

I have informed the above named patient or the person authorized to extend consent on the patient's behalf,of the medical condition requiring surgical treatment and/or the further diagnostic procedures referred to above. I have explained,consistent with accepted medical judgment, the nature and purposes of the treatment or procedures, the reasonable (1) possible alternatives, (2) risks and benefits, and (3) complications in the treatment or procedure consented to.

Physician / Provider:	SIGN:	DATE:	TIME: