3-Hole 1/4 2 3/4 c-to-c

UNIVERSAL CONFIRMATION / CONSENT FOR SURGERIES AND MEDICAL PROCEDURES

Patient Name: ____ DOB: ____________________

DO NOT SIGN UNLESS YOU HAVE THOROUGHLY READ AND YOU UNDERSTAND THIS FORM. IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION PRESENTED, ASK YOUR PROVIDER BEFORE SIGNING THIS CONSENT FORM!

I hereby authorize ______________________________ and his/her associates to perform the following surgery/procedure:

____

____

____

1. I hereby authorize and direct the above-named provider to perform such additional services for me as they may deem necessary and reasonable, including, but not limited to the performance of services involving pathology and radiology, and the administration of blood products, and I hereby consent.
2. I recognize that, during the course of the operation, unforeseen conditions may require additional or different procedures than set forth above. I therefore further authorize and request that the above-named provider perform such procedures as are in their professional judgment, necessary and desirable. The authority granted under this paragraph shall extend to remedying conditions that are not known at the time of the beginning of the operation.
3. I hereby authorize the hospital Pathologist to use his discretion in the disposal of any severed tissue or body part.

☐ **Blood Transfusion: Possible Risks** of this blood component transfusion include but are not limited to: itching, rash, hives and/or flushing; fever and chills; difficulty breathing with elevated blood pressure; decreased blood pressure with respiratory failure; hemolysis; anaphylaxis; bacterial contamination with possible sepsis; viral infections.

Please read and initial one of the options below:

________ The reason for recommending this operation or procedure along with the risk and alternative treatments or tests have been explained to me by my provider. My provider has provided sufficient information about this procedure or operation and I wish to proceed.

OR

________ I have told my provider that I have elected not to have all the facts and risk explained to me and I wish to proceed.

____ ____________________

Signature of Patient or Patient Representative (and relationship) **Date**

Reason why patient cannot sign (if signed by patient representative) ______________________________

______________________________ ____________________ ____________________

Witness to Patient Confirmation Statement **Relationship / Credentials** **Date**

FOR Provider USE ONLY (may be documented elsewhere in medical record):

Provider documentation of Informed Consent and risks discussed with patient, if not below, may be found:

H & P **Progress Note** **ED Notes**

Possible Risks of this surgery/procedure include, but are not limited to: ______________________________

____

____

____

PROVIDER DECLARATION: I have reviewed the anesthetics/surgery/procedure/other medical services listed above with the patient. Unless the patient has declined information as documented above, I have described the procedure, its possible risks and benefits, alternatives with their risks, including the risk of not having the procedure and the likelihood of achieving care goals. To the best of my knowledge, the patient has been adequately informed, understands the information and has consented to the procedure.

____ ____________________

Signature of Provider **Date**

8721-602 (Rev. 4/21

PLACE PATIENT
ID LABEL HERE

Alaska
Medical Center

UNIVERSAL CONFIRMATION / CONSENT FOR SURGERIES AND MEDICAL PROCEDURES

DOCUMENTATION OF PHONE CONSENT

Patient Name: ____

Procedure: ____

____

____

PROVIDER DECLARATION: I have reviewed the anesthetics/surgery/procedure/other medical services listed above with the patient's Representative by phone. I have described the procedure, its possible risks and benefits, alternatives with their risks, and the likelihood of achieving care goals. To the best of my knowledge, the Representative has been adequately informed, understands the information and has consented to the procedure.

____

Name and Relationship of Representative

Reason why patient cannot sign: ____

____

____ ____________________

Signature of Provider **Date**

____ ____________________

Witness to phone consent **Date**

REFUSAL OF BLOOD

I refused to consent to the blood product transfusion recommended by my provider and accept the risks of this action, including death.

☐ I have discussed this with my provider.

____

Signature of Patient or Representative

____

Signature of Witness

____

Date

If signed by other than patient, indicate relationship: ____

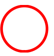
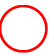
(Parent, legal guardian, etc.)

8721-602 (Rev 4/21

PLACE PATIENT
ID LABEL HERE

UNIVERSAL CONFIRMATION /CONSENT
FOR SURGERIES AND MEDICAL PROCEDURES

TAB 7

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