EMORY HEALTHCARE

Consent to Surgical or Medical Treatment

Diagnosis:

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Name of Procedure:

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l. I understand the following about the procedure named above:

a. Nature and purpose of procedure (Describe in laymen's terms):

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b. Material risks of the procedure include, but are not limited to: DEATH, RESPIRATORY ARREST, CARDIAC ARREST, BRAIN DAMAGE, DISFIGURING SCAR, PARAPLEGIA OR QUADRIPLEGIA, PARALYSIS OR PARTIAL PARALYSIS, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, SEVERE LOSS OF BLOOD, ALLERGIC REACTION AND INFECTION. These are material risks of any procedure. Other risks and/or the potential side effects of this procedure include, but may not be limited to:

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c. Likelihood of success: ❑ Good ❑ Fair ❑ Poor ❑ Unknown because:

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d. Practical alternatives to procedure:

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e. Prognosis if procedure rejected: ❑ Good ❑ Fair ❑ Poor ❑ Unknown because:

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f. ❑ If applicable, and as discussed with my physician/surgeon, I temporarily suspend my consent to any Do Not Resuscitate (DNR) or Do Not Intubate (DNI) order during the procedure and recovery period, unless indicated otherwise:

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2. The nature and purpose of the procedure identified above have been explained to me, including the potential benefits and side effects of the procedure. I understand the practical alternatives to the procedure and their risks and I hereby consent to the performance of this procedure by ________________________ and/or any assistants who may be present. I also consent to the administration of anesthesia, (including but not limited to general anesthesia, spinal anesthesia, and/or major regional anesthesia), intravenous procedural sedation, and/or the intravenous or intraductal injection (or administration by any other route) of a contrast material, as determined by my physician/surgeon or his/her qualified designee. I understand that anesthesia, sedation,

and/or contrast material will be administered by or under the direction and supervision of The Emory Clinic, Emory Specialty Associates, or by a designated independent physician practice group. I understand that some or all of the healthcare professionals performing services as part of my procedures may be independent contractors who are not employees or agents of Emory Healthcare, Inc. or the Hospitals. I understand that independent contractors are responsible for their own actions and that Emory Healthcare, Inc. and the Hospitals are not liable for the acts or omissions of any such independent contractors.

3. I realize that during the procedure, the physician/surgeon or his/her qualified designee, may become aware of conditions which were not apparent before the start of the procedure, or may determine that additional or different operations or procedures are necessary or appropriate. I therefore authorize the above-named physician/surgeon, or his/her qualified designee, and/or any assistants who may be present, to perform additional or different operations or procedures the physician/surgeon, or his/her qualified designee, deems necessary or advisable; so long as these additional procedures do not conflict with my stated DNR or DNI code status as indicated above.
4. I acknowledge and agree that any tissue, organ, specimen, member or implant, removed or severed from my body during the procedure described above, may be retained, preserved, analyzed, and/or disposed of, or may otherwise be used for any lawful purpose, including medical education and teaching, by Emory Healthcare, The Emory Hospitals, The Emory Clinic, Emory Specialty Associates, and/or a designated independent pathology contractor service.
5. I acknowledge that the physician/surgeon, or his/her designee, may photograph, videotape or otherwise make recordings of me or my image before, during, or after this procedure for purposes related to care, treatment and/or medical education.
6. I understand that this consent form will be valid for 30 days, unless I have signed this consent form in conjunction with an admission to the hospital, in which case this consent will be valid for 30 days from the date of admission or for the duration of my hospitalization, whichever is greater.
7. I understand that the physician/surgeon/anesthesiologist or other qualified healthcare professional will be present for the key portions of my procedure. However, because he/she may be coordinating various procedures which overlap with my procedure, I further understand that he/she may not be present during some non-key elements of my procedure, which will be covered by another qualified healthcare professional member of the procedural team.
8. I acknowledge that no guarantees have been made concerning the outcome of the surgical or medical treatment, and I realize that the practice of medicine and surgery is not an exact science. I have read all of the above information, and I have been given the chance to ask any questions, and all of my questions have been answered to my satisfaction.

I REQUEST AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE AS OUTLINED ABOVE.

______________________________	__________	__________	______________________________
Signature of Patient/Authorized Representative	Date	Time	If not patient, relationship to patient

Printed Name of Patient/Authorized Representative (print) ______________________________

❑ Check if telephone consent given

Witness to Signature: ______________________________ Date: __________ Time: __________
(Witness signature required only for telephone consents)

Interpreter Name/Operator Number: ______________________________

Signature of Person Obtaining Consent: ______________________________ Date: __________ Time: __________