



**REQUEST AND AUTHORIZATION FORM
FOR OPERATIVE OR OTHER PROCEDURE**



1. I request and authorize Dr. _____ (Attending Physician) and/or his/her associates to perform the following procedure(s) on: _____

(name of patient)

Description of procedure(s): _____

- 2. I further request the administration of such anesthetics as deemed necessary or desirable. I understand that administration of anesthesia carries risks separate and apart from the risks of the surgical procedure.
- 3. I further consent to the administration of such drugs, infusions, plasma, blood transfusions, or any other treatment, injection or procedure deemed necessary in the judgement of the attending physicians. The possible need for, risks of, and alternatives, including possible results of non-treatment, to blood transfusion have been explained to me.
- 4. The attending physician or his/her designee has provided sufficient information to give me a general understanding of the nature and purpose of the operations and/or procedures, the benefits thereof and the usual and most frequent risks and hazards involved. Alternative methods of treatment and the risks and benefits of these alternatives, including possible results of non-treatment, have also been explained to me.
- 5. It has been explained to me that during the course of the procedure unforeseen conditions may arise which may necessitate surgical or other procedures in addition to or different from those contemplated. I therefore further authorize the above-named physician and/or associates or assistants to perform such additional surgery or other procedures as (s)he or they deem necessary or desirable.
- 6. I recognize that the results from the practice of medicine and surgery are not absolutely predictable, and I acknowledge that no guarantees or assurances have or can be made concerning the results of such operation(s) or procedure(s).
- 7. I agree that any tissues, organs and body fluids removed during the course of the operation(s) or procedure(s) may be examined, documented, preserved and/or disposed of in a manner considered proper for purposes of diagnosis, study and advancement of medical knowledge, provided the patient's identity is not revealed.



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(Attending Physician) and/or designee

Relationship to patient (if other than patient)

Date

I CERTIFY THAT I HAVE READ THIS FORM, OR IT WAS READ TO ME, AND THAT I FULLY UNDERSTAND IT, THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, AND THE ANSWERS AND ADDITIONAL INFORMATION PROVIDED HAVE MET WITH MY SATISFACTION.

Signature of Patient/Next of Kin/Guardian

Date

Relationship to Patient (if other than patient)

I certify that the patient/next of kin/guardian has answered "yes" to all of the following questions:

- a) Did your attending physician or his/her designee explain the procedure to you?
- b) Have all your questions about the procedure been answered?
- c) Have you consented to the proposed procedure?
- d) Is this your signature on the consent form?

Witness (Attending physician or designee)

M.D.

Date