McLAREN CENTRAL MICHIGAN
1221 SOUTH DRIVE, MT. PLEASANT, MI 48858

CONSENT FOR OPERATION AND/OR PROCEDURE

PATIENT LABEL

Date _____

1. I _____ the undersigned, do hereby certify that I understand the explanation that has been given to me, and I authorize the following surgery and/or procedure/s:

   _____

   _____

   I understand my diagnosis is: _____

   _____

2. This explanation included reasons, advantages and possible complications of all procedures. The alternative modes of treatment and prognosis if the treatment is not rendered have been discussed. I understand the risks associated with the procedures. The benefits and side effects of the procedures have been explained to me, as well as the estimated period of hospitalization and what to expect for a recovery period. It has also been explained to me any effects to my future health. I am aware in the practice of medicine, other unexpected risks of complications not discussed with me may occur.
3. In light of the above information, I desire to have the above-named surgery/procedures performed by:

   Dr. _____ or his/her associates together with any additional procedures that may be necessary.
4. I agree that in addition to the physician and hospital staff, that there may be observers in the operating room for educational purposes: Yes: _____ No: _____ (please check one).
5. I have been informed and understand that anesthetic may be used in connection with the described procedures. I understand the risks, advantages and possible complications and consent to the administration of such anesthetics as may be considered necessary or advisable
6. Any tissue surgically removed may be disposed of by the surgeon or hospital in accordance with their practice.
7. Any photographs taken during the surgery/procedures are for medical purposes and become part of the hospital's or physician's office record.
8. Aftercare may be administered by any member of the hospital's staff. The physician may discharge me when, in his/her opinion, my condition warrants. Arrangements for continued treatment and aftercare shall be my responsibility.

_____
Signature of Patient or Guardian

Date: _____ Time: _____

_____
Witness

Date: _____ Time: _____

_____
Signature of Surgeon/Physician

Date: _____ Time: _____

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