**McLaren Flint**

**FLINT, MICHIGAN**

# CONSENT TO OPERATION OR OTHER PROCEDURE

1. I have been told by my physician, _____, that my present condition or conditions may effectively be treated by the following procedure(s):_____

_____

I hereby authorize my physician and the associates and assistants selected by him to perform the described procedure(s).

2. I understand that unforeseen circumstances may arise during an operation or procedure, and may require performance of operations or procedures different from or in addition to those originally planned, in order to safeguard and promote the well being of the patient. I consent to such other or additional surgery, procedures, or therapies as may be considered necessary or advisable by my doctors under such circumstances. I authorize and request that my Physician, his assistants or his designees, perform such additional procedures as are necessary. If at an outpatient facility, I consent to transfer to McLaren Flint main campus in the event that my condition warrants such a transfer.
3. I am aware that McLaren Flint is a resident teaching facility and that physician residents and/or medical students may be involved with my care under the supervision of my physician. I consent to their involvement and participation in my treatment planning and care.
4. I understand that such procedure(s) may involve transfusion of blood or blood cell products. I have been made aware that, despite routine screening procedures, use of blood and blood cell products always carries some risk of transmissible disease, including hepatitis virus, or other blood-borne agents. I give authorization to administer to me during the procedure(s):
   ( ) regular blood or blood products from the Blood Bank;
   ( ) autologous blood only (blood I have given); In the absence of the sufficient quantity of blood I have given, I understand regular blood or blood products from the Blood Bank will be used.
   ( ) designated (directed) donations only;
   ( ) no blood products.
5. I agree to the use of anesthesia and/ or sedation as deemed appropriate by the anesthesiologist or his/her designee. It has been explained to me that all forms of anesthesia involve some risks and although rare, unexpected severe complications may occur including but not limited to mouth or throat pain, injury to mouth or teeth, infection, injury to blood vessels, headache, backache and others. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia. I consent to the anesthesia service discussed with the anesthesia provider. I also consent to an alternative type of anesthesia if necessary as deemed appropriate by my anesthesia provider.
6. I acknowledge that full discussion has taken place between my physician and me prior to the procedure(s) herein authorized, that the advantages and disadvantages of such procedure(s) including the risk of infection, have been explained to me, and that alternative methods of treatment have been discussed with me. I have been made aware of certain risk(s) and consequences that are associatedwith the procedure(s) described in Paragraph 1 and understand that submitting to the procedure(s) may endanger my life or future health.I am aware that the practice of medicine and of surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).

Signature of Patient: _____ Date & Time _____

If patient is unable to sign or is a minor, complete the following:
Signature of Next of Kin
or Legal Guardian: _____ Date & Time _____

Signature Witnessed by: _____ Date & Time _____

I, Dr. _____, hereby attest to providing information regarding the patient's risk, including risk of infection, benefits, as well as alternative methods of treatment available to aid the patient and family in the decision process regarding this procedure(s).

Signature of Physician: _____ Date & Time _____

Anesthesia Provider Signature: _____ Date & Time _____

**CONSENT TO OPERATION OR OTHER PROCEDURE**

820b

1761 (10/3/13) (Intranet)

PT.

MR.#/RM.

DR.