Virginia Mason™

How to use this form

- Complete the form online.
- Move the cursor into the grayed line area and click the mouse.
- Type your entries directly into the space provided.
- Move through the grayed cells by using the TAB key.

Printing

- When complete, print the form by clicking the print button on this form.
- Review the form for accuracy in print form.
- If any of the fields are inaccurate or cut-off, correct these in the online form and reprint.

Signatures

- After the consent discussion has been completed, the Responsible Physician must sign and date the attestation.
- The patient or legal guardian must sign and date the form.
- A witness to the signature must sign and date the form.
- The signatures do not have to occur in any particular order (i.e. physician after the patient).

Completing the process

- Make a photocopy of the completed, signed and dated form.
  - Original with medical record
  - Copy to patient/legal guardian

Forms with frequently used information may be saved to a local directory.

CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS AND RENDERING OF OTHER MEDICAL SERVICES

1. **Physician:** _____ (name) will be performing the key portions of the procedure(s).
2. **Procedure:** The procedure(s) as listed below and planned for treatment of my condition(s) has been explained to me by my physician: _____
3. I hereby authorize and direct the physician listed above and assistants as may be required, to perform my procedure(s). I have been informed of the nature and participation of assistants such as medical residents or qualified non-physician practitioners involved in the performance of important aspects of my procedure.
4. I recognize that, during the course of the procedure, unforeseen conditions may require additional or different procedures than those listed above. I authorize the performance of such surgical or other procedures that may be deemed medically necessary, in the exercise of professional judgment.
5. The following information has been explained to me:
   - The kind of procedure(s) and what it will involve.
   - The anticipated benefits and results of the procedure(s). I know that results cannot be guaranteed.
   - The known material risks of this procedure, including those that may be serious and possibly fatal, which include: stroke, device failure, infection, neurologic impairment, blood clots, heart attack, allergic reactions, respiratory failure, organ failure, bleeding, injury to surrounding structures, and risk of blood transfusions. Other risks include: *(or indicate "Not Applicable")* physician: _____
   - Alternative treatment options, including not having the procedure, and the risks and benefits of those alternatives.
6. I have been informed that I will receive anesthesia and/or sedation medication, administered by a qualified provider. There are risks and side effects associated with anesthesia and sedation, including those that may be serious and possibly fatal, and an anesthesia provider will discuss these with me before my procedure(s). I consent to the administration of anesthesia and/or sedation medication.
7. I consent to the use of transfused blood and/or blood products as deemed medically necessary. I understand that blood and blood products involve the risk of allergic reaction, fever, hives, and in rare circumstances, infectious diseases such as hepatitis and HIV/AIDS. I understand that precautions are taken by the blood bank in screening donors and in matching blood for transfusion to minimize those risks.
   OR _____ (patient's initials) **I do not consent to blood transfusion.** (Must also sign "Refusal of Transfusion" form.)
8. I acknowledge that any tissues/parts surgically removed will be disposed of in accordance with accustomed practices.
9. My physician may also allow observers, who will not assist with my procedure(s), including other physicians, health care students, and suppliers of medical devices to be used in my procedure. I give permission for observers.
10. In the course of my procedure(s) I understand technology may be involved in imaging of the site to include photography and video. If so, the images may become a part of my medical record and will have the same confidentiality protections as other parts of the medical record.

I have had sufficient opportunity to discuss my condition and treatment with my physician, and all of my questions have been answered to my satisfaction. I have read and fully understand this form, and I voluntarily authorize and consent to this operation/procedure or treatment. I understand I am free to refuse consent to any procedure, and I have the right to make decisions without coercion. I hereby give my consent for the above procedure(s).

Signature of Patient or Patient's Authorized Representative & Relationship	Date (month/day/year)	Time
Signature of Witness to Patient/Authorized Representative's Signature	Date (month/day/year)	Time

Responsible Physician's Attestation: I have explained the procedures or treatments stated on this form including possible risks, complications, alternative treatments, and anticipated results, to the patient/legal representative. To the best of my knowledge, this patient has been adequately informed and has consented.

Signature of Responsible Physician	Date (month/day/year)	Time

PATIENT NAME & ID #

Reset Form | Print Form

VIRGINIA MASON MEDICAL CENTER – Seattle WA

Consent to Operation, Administration of Anesthetics and Rendering of Other Medical Services

* A D M C N S N T *