

IRB Approved

Appendix A

SURGICAL PATIENT CONSENT FORM

I, _____, have consented to the
(Name of Patient)

performance of _____
(Technical Name of Operation andlor Procedures)

which involves _____
(Explanation of Procedure)

Performing physician's initials (to be initiated in OR Suite): _____

At the _____ Hospital, located in _____ by _____, M.D., andlor
such assistants as may be selected by him.

It has been explained to me that during the course of the operation or procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in paragraph 1. I therefore authorize and request that the above named physician, his assistant or his designees perform such procedures as are necessary and desirable in the exercise of his professional judgment.

I consent to the administration of such anesthetics as may be considered necessary or advisable by the anesthetic or physician responsible for this service.

I understand that, unless I instruct the hospital otherwise, all tissues, surgical specimens and materials removed during my surgery will be disposed of by the hospital in accordance with customary hospital procedures and may be used for educational and research purposes by organizations other than the hospital including research by academic and commercial organizations both foreign and domestic. I further understand that this research could result in the development of new diagnostic and treatment products, services and devices. I hereby give my permission for this commercial use and waive any future claims against the hospital or the research organization. I understand that I will not receive financial remuneration from this activity.

If any device or material is implanted which must be tracked or reported in accordance with the law(s), I consent to the release of information required for purpose of tracking the device/material. The nature and purpose of the operation andlor procedure, the use of anesthetics, possible alternative methods of treatment, the risks involved and the possibility of complications have been explained to me.

The risks and benefits of receiving blood transfusions or one of its products have been explained to me. I understand that if I need a transfusion in the interest of my health and proper medical care, risks exist, hepatitis, acquired immune deficiency syndrome and other blood borne diseases, despite the fact that the blood has been carefully tested. The alternative to transfusions and the availability of autologous blood have been explained to me and I have had the opportunity to ask questions. I consent to the transfusion(s).

I have been informed that there are other risks such as severe loss of blood, reaction to blood or blood products, infections, and cardiac arrest, which are attendant to the performance of any surgical procedure.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operations and/or procedures.

I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia and treatment, risks of non-treatment, the procedure to be used, and the risks and hazards involved, and I believe I have sufficient information to give this informed consent.

I certify that I have read and fully understand the above consent, and I further certify that have sufficiently been informed to my full satisfaction.

Witnessed by _____

If patient is a minor or is unable to sign, complete the following:

Patient is a minor, _____ years of age.

Patient is unable to sign because _____

Signature of Nearest Relative or Guardian

Witness