## PHYSICIAN DOCUMENTATION OF INFORMED CONSENT FOR SURGERY/MEDICAL PROCEDURE(S)

**Diagnosis(es) indicated need for operation/procedure(s):** _____

**Planned operation/procedure(s):** _____

**Physician documentation of informed consent** (required prior to incision or initiation of operation/procedure except in emergency):

I, the undersigned physician, hereby certify that I have discussed the procedure named above with this patient or other legally responsible person, including the risks and benefits of the procedure, any adverse reactions that may reasonably be expected to occur, any alternative efficacious methods of treatment which may be medically viable and any research or economic interest I may have regarding this treatment. I further certify that the patient was encouraged to ask questions and that all questions were answered. Specific risks for this procedure include the following:

_____

_____ _____
Physician signature Date

_____ _____
Physician print name Time a.m./p.m.

## PATIENT CONSENT FOR SURGERY/MEDICAL PROCEDURE(S)

I, _____ , hereby authorize _____
to perform the above named operation/procedure.

- I understand that the operation/procedure is performed by an operating team which may consist of (1) operating physician(s), (2) other physicians participating in the operation/procedure, (3) residents, (4) anesthesiologist and his/her associates such as a certified registered nurse anesthetist and anesthesia technician(s) and/or (5) other personnel.
- In the event a practitioner will be performing a significant surgical task, that information will be provided with documentation on the form "Identification of Practitioner(s) Performing Significant Surgical Tasks."
- I consent to the administration of anesthetics or conscious sedation agents as considered necessary by my physician or anesthesiologist, and the benefits, alternatives and risks have been explained to me in a way I understand.
- I understand that unforeseen conditions may arise during the course of the operation/procedure, which may require additional or different procedures than those indicated above, and that it is not reasonable to expect my physician to be able to anticipate nor explain all risks and complications, and further that an undesirable result does not necessarily indicate an error in judgment. I, therefore, authorize and request the above-named physician to perform such operation/procedure(s) that are considered necessary in her/her professional judgment.
- The nature and purpose of the operation, the risks involved, benefits, possible alternative methods of treatment, possible risks and complications of each alternative and possible consequences of remaining untreated have been explained to me by the operating physician.
- Any explanted devices shall be held at Adventist Health Tillamook as specified by hospital policy. Disposal of all devices shall also be per hospital policy.
- I have had the opportunity to ask questions, and they have been answered to my satisfaction.

_____ _____ _____
Signature of patient or legally responsible person Date Time a.m./p.m.

_____ _____ _____
Witness to signature Date Time a.m./p.m.

I authorize my physician and Adventist Health Tillamook to permit, for educational purposes only, the presence of such observers as they may deem fit to admit in addition to physicians and hospital personnel while I am undergoing operative surgery, childbirth, examination and/or treatment.

I hereby grant permission for _____ to be present during conduct of this surgery

for the purpose of: _____

_____ _____ _____
Patient signature Date Time a.m./p.m.


**Consent/Refusal/ Request/Release**

**Consent/Authorization for Procedure**
Adventist Health Tillamook
1000 Third St., Tillamook OR 97141

{ Patient label }