

**IMPORTANT**

Sign only in one place after carefully reading entire form

**PATIENT INFORMED CONSENT**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
(name of physician) has explained to me in a way that I understand:

- 1. The general procedure or treatment to be undertaken: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ ; and
- 2. There may be other procedures or methods of treatment; and \_\_\_\_\_
- 3. Specific risks for this procedure include the following: \_\_\_\_\_  
\_\_\_\_\_

**SIGN IN THIS BOX ONLY IF YOU REQUESTED  
AND RECEIVED MORE DETAILED INFORMATION**

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the materiel risks of the procedure or treatment. I give my permission and consent to the procedure or treatment.

\_\_\_\_\_ X \_\_\_\_\_  
Date Patient's Signature

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Print Name \_\_\_\_\_ Time \_\_\_\_\_ am/pm  
 Witness \_\_\_\_\_ Date \_\_\_\_\_  
 Print Name \_\_\_\_\_ Time \_\_\_\_\_ am/pm

**PHYSICIAN DOCUMENTATION OF INFORMED CONSENT** (required prior to incision or initiation of operations/procedures except in an 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.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_  
Print Name: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Tillamook Regional Medical Center  
1000 3rd St., Tillamook, OR 97141

[Patient Label]



**IDENTIFICATION OF PRACTITIONER(S)  
PERFORMING SIGNIFICANT SURGICAL TASKS**

Name of Patient: \_\_\_\_\_ Patient ID Number: \_\_\_\_\_

Name of Procedure(s): \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

Primary Surgeon: \_\_\_\_\_

First Assist: \_\_\_\_\_

The Centers for Medicare and Medicaid Services require that you be informed of the name of each practitioner(s) performing significant surgical tasks during your operation. "Significant surgical tasks" include, but are not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues. If a resident physician will be performing any significant surgical tasks, only "resident" must be indicated, rather than the resident's name.

I have been informed that the following practitioner(s) will be performing the following significant surgical tasks:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand and agree that if the practitioner named above is unable to perform or complete the task, a substitute practitioner may do so, and that this information will be recorded in my medical record. I understand that the practitioners named above are not employees or agents of the hospital. They are independent contractors.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient / Patent / Conservator / Guardian

Print Name: \_\_\_\_\_ Time: \_\_\_\_\_ a.m. / p.m.  
Patient / Patent / Conservator / Guardian

If signed by other than patient, indicate name and relationship: \_\_\_\_\_

\_\_\_\_\_

Witness: \_\_\_\_\_ Print Name: \_\_\_\_\_

I, the undersigned physician, hereby certify that I have discussed with the patient or the patient's legal representative the role and responsibility of each practitioner performing a significant surgical task. I encouraged the patient to ask questions and all questions were answered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Physician

Print Name: \_\_\_\_\_ Time: \_\_\_\_\_ a.m. / p.m.  
Physician

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**Patient Informed Consent**  
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