



2CONS

UNIVERSAL CONFIRMATION / CONSENT FOR SURGERIES AND MEDICAL PROCEDURES

Patient Name: _____ DOB: _____

DO NOT SIGN UNLESS YOU HAVE THOROUGHLY READ AND YOU UNDERSTAND THIS FORM. IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION PRESENTED, ASK YOUR PROVIDER BEFORE SIGNING THIS CONSENT FORM!

 I hereby authorize _____ and his/her associates to perform the following surgery/procedure:

1. I hereby authorize and direct the above-named provider to perform such additional services for me as they may deem necessary and reasonable, including, but not limited to the performance of services involving pathology and radiology, and the administration of blood products, and I hereby consent.
2. I recognize that, during the course of the operation, unforeseen conditions may require additional or different procedures than set forth above. I therefore further authorize and request that the above-named provider perform such procedures as are in their professional judgment, necessary and desirable. The authority granted under this paragraph shall extend to remedying conditions that are not known at the time of the beginning of the operation.
3. I hereby authorize the hospital Pathologist to use their discretion in the disposal of any severed tissue or body part.

☐ **Blood Transfusion: Possible Risks** of this blood component transfusion include but are not limited to: itching, rash, hives and/or flushing; fever and chills; difficulty breathing with elevated blood pressure; decreased blood pressure with respiratory failure; hemolysis; anaphylaxis; bacterial contamination with possible sepsis; viral infections.

Please read and initial one of the options below:

_____ The reason for recommending this operation or procedure along with the risk and alternative treatments or tests have been explained to me by my provider. My provider has provided sufficient information about this procedure or operation and I wish to proceed.

OR

_____ I have told my provider that I have elected not to have all the facts and risk explained to me and I wish to proceed.

Signature of Patient or Patient Representative (and relationship)

Date and Time
Reason why patient cannot sign (if signed by patient representative) _____

Witness to patient confirmation

Relationship / Credentials

Date and Time
FOR Provider USE ONLY (may be documented elsewhere in medical record):
Provider documentation of Informed Consent and risks discussed with patient, if not below, may be found:
H & P
Progress Note
ED Notes
Possible Risks of this surgery/procedure include, but are not limited to: _____

PROVIDER DECLARATION: I have reviewed the anesthetics/surgery/procedure/other medical services listed above with the patient. Unless the patient has declined information as documented above, I have described the procedure, its possible risks and benefits, alternatives with their risks, including the risk of not having the procedure and the likelihood of achieving care goals. To the best of my knowledge, the patient has been adequately informed, understands the information and has consented to the procedure.

Signature of Provider

Date and Time

8721-602 (Rev. 10/24)

 PLACE PATIENT
ID LABEL HERE

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DOCUMENTATION OF PHONE CONSENT

Patient Name: _____

Procedure: _____

PROVIDER DECLARATION: I have reviewed the anesthesias/surgery/procedure/other medical services listed above with the patient's Representative by phone. I have described the procedure, its possible risks and benefits, alternatives with their risks, and the likelihood of achieving care goals. To the best of my knowledge, the Representative has been adequately informed, understands the information and has consented to the procedure.

Name and Relationship of Representative _____

Reason why patient cannot sign: _____

Signature of Provider _____

Date and time _____

Witness to phone consent _____

Date and time _____

REFUSAL OF BLOOD

I refused to consent to the blood product transfusion recommended by my provider and accept the risks of this action, including death. ☐ I have discussed this with my provider.

Signature of Patient or Representative _____

Signature of Witness _____

Date and time _____

If signed by other than patient, indicate relationship: _____

(Parent, legal guardian, etc.) _____

PLACE PATIENT
ID LABEL HERE

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