MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

Consent for Operative Care, Medical Treatment, Anesthesia, Procedural Sedation, or Other Procedure

☐ Hale Ho'ola Hamakua
☐ Ka'u Hospital

Date of Procedure: _____

Valid for 30 days from patient signature date

This form has been designed to acknowledge your acceptance of treatment recommended by your physician. Please feel free to ask any questions.

I hereby authorize Dr. _____ and any associate or assistant involved in my care to treat the following **CONDITION(s)** which has (have) been explained to me.

MEDICAL LANGUAGE: _____

ORDINARY / LAY LANGUAGE: _____

The **PROCEDURE(s)** planned for my treatment of my condition(s) has (have) been explained to me by my physician as follows:

MEDICAL LANGUAGE: _____

ORDINARY / LAY LANGUAGE: _____

- I authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable, should unforeseen circumstances arise during the procedure.
- I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.
- No promise or guarantee has been made to me as to result or cure.
- I have been informed of the benefits and advantages of alternative methods, or of no intervention.

Any sections below, which do not apply to the proposed treatment, may be crossed out. Both physician and patient must initial all sections crossed out.

- If I need anesthesia my anesthesiologist or nurse anesthetist is responsible to inform me of the plan, risks, benefits and alternatives.
- I consent to the administration of anesthesia (general, spinal, regional, and/or local) or procedural sedation by my attending physician, an anesthesiologist, a nurse anesthetist, or other qualified party (under the direction of a physician) as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney. These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.
- Any tissues or part surgically removed may be disposed of by the hospital or physician in accordance with customary practice.
- I consent to the photographing, video monitoring or other media of the operation or procedure to be performed, including appropriate portions of my body, for the internal purpose of performance improvement, provided that my identity is not revealed by the picture or by descriptive text accompanying them.
- I consent to the observation of the operative procedure for the purpose of advancing medical education.
- I consent to the use of blood and blood products as deemed necessary. I have been informed of the risks, which are transmission of disease, allergic reactions and other unusual reactions, as well as the alternatives and benefits of blood and blood products.

  I do NOT consent to the use of blood or blood products_____(patient initials)

Any additional comments may be inserted here: _____

FULL DISCLOSURE

I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF:

a. My diagnosis or probable diagnosis.
b. The nature of the proposed care, treatment, services, interventions, medications, and procedures.
c. The potential benefits, risks or side effects, including problems related to recuperation.
d. The likelihood of achieving care, treatment, and service goals.
e. The reasonable alternatives to the proposed care, treatment and services.
f. The relevant risks, benefits, and side effects related to alternatives.
g. Any limitations on the confidentiality of information learned from or about me.

_____
Patient/Legal Rep. Signature Date Time

Relationship (if not self):

☐ Parent of Minor ☐ DPOAH ☐ Guardian ☐ Surrogate

☐ Other _____

_____
Witness Signature Date Time

_____
Physician Signature Date Time