CONSENT TO SURGICAL, INVASIVE, OR DIAGNOSTIC PROCEDURE

1. I agree to allow Dr. ________________________________
   (Attending Physician)
   to perform a/an ________________________________
   (Procedure, Surgery)
   ________________________________________________
   (Procedure, Surgery)
   on ________________________________________________
   ("Me" or Patient’s Name)

2. The procedure/surgery has been explained to me by Dr. ________________.

3. In making my decision to have this procedure/surgery, I understand the
   risks and the possible benefits. I also understand the possible side
   effects and possible problems of the healing process.

4. I understand the alternatives to this procedure/surgery and the risks and
   benefits of the alternatives. I also understand the risks and benefits of not
   having this procedure/surgery.

5. I understand that the procedure/surgery may not have the result I hope it
   will have.

6. In agreeing to have this procedure/surgery, I accept the risks, the side
   effects and the possible problems from the healing process that have been
   explained to me.

7. I understand that residents and licensed medical providers who are not
   physicians may perform important surgical tasks during this
   procedure/surgery, and that medical students may also be involved, all
   under the supervision of the Attending Physician.

8. If something unexpected occurs during this procedure, I agree to treatment
   that the Attending Physician or a physician who is brought in by the
   Attending Physician thinks is necessary.
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9. I agree to allow this hospital to keep, use or properly dispose of tissue and parts of organs that are removed during this procedure.

10. I have had enough time to discuss and think about the planned procedure/surgery and all of my questions have been answered. I have enough information to make an informed decision. I agree to this procedure/surgery.

_____________________________  ______________________________   _________________
Patient/Representative (print)                           Signature                             Relationship

Date        Time

WITNESS: I have witnessed the patient/representative sign this form.

______________________________         __________________________________         ______________
Witness’s Name (print)                                                   Signature                       Date

INTERPRETER: I have interpreted truthfully and accurately to the best of my ability.

______________________________       __________________________________         ______________
Interpreter’s Name (print)                                     Signature                        Date

PHYSICIAN’S CERTIFICATION

I have discussed with the patient/representative the relevant potential benefits, risks and side effects, possible problems related to recuperation, likelihood of achieving our goal, as well as the possible results of not having this procedure/surgery. Additionally, I have provided the patient/representative with the opportunity to ask questions, and I have answered all questions that were asked. I believe that he/she understands what we have discussed, and that he/she has given an informed consent.

____________________________   ____________________________  __________
Physician (print)                               Signature           Date