

Operating Room Nursing  
**CONSENT FOR OPERATION OR OTHER PROCEDURE**

I hereby authorize and direct Dr. \_\_\_\_\_ and whomever she/he may designate as his/her associates, to perform upon \_\_\_\_\_ the following operation(s) procedure(s):

and if any unforeseen condition arises in the course of the operation/procedure calling for, in his/her judgment, procedures in addition to or different from those stated above, I further request and authorize him/her and his/her associates and/or assistants to do whatever she/he deems advisable.

The nature and purpose of the operation/procedure, possible alternative methods of treatment, the potential risks involved, possibility of complications as well as the benefits expected have been fully explained to me by my physician. The substantial risks, hazards, and potential complications include, but are not limited to: infections, excessive bleeding, inadvertent puncture, laceration, or other injuries or damage to organs, blood vessels or nerves and the possible need for additional procedures/surgery to repair such injuries. If applicable, I completely understand additional risks associated with this procedure (s) to be as follows:

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained or the likelihood of success.

I consent to the administration of anesthesia agents by my physician or other assigned anesthetist.  
I exclude use of the following anesthesia agents:

\_\_\_\_\_ initials \_\_\_\_\_

I understand that DO NOT RESUSCITATE orders **ARE** suspended during surgery and certain invasive diagnostic procedures. However, I do have the right to choose and  request otherwise. IF BOX IS CHECKED, DOCUMENT ON PROGRESS NOTES IN MEDICAL RECORD.

I consent to the disposal of tissues, parts or members by the authorities of Chestnut Hill Hospital and/or the Pathologist examining such specimens, which may be removed during the operation or other invasive procedure.

I consent to the photographing or videotaping of the operation/procedures to be performed, including appropriate portions of my body, for medical and medical record documentation purposes provided said photographs and videotapes are maintained and released in accordance with medical record regulations.

I authorize and consent to the transfusion of blood and blood products to me as necessary during my surgery and such additional transfusions as may be deemed advisable in the judgment of my physician, his/her associates or assistants.

- 1) I understand that the risk associated with the transfusion of blood and blood products includes death, infectious diseases such as Hepatitis and Human Immunodeficiency Virus (HIV), the virus which causes AIDS, and allergic reactions.
- 2) Alternatives to transfusions have been discussed with me by my physician
- 3) I refuse consent for the administration of blood, blood components, and blood products. The possible risks and complications of my refusal have been fully explained to me. Initials \_\_\_\_\_.

I authorize and consent to the presence of equipment representative(s) for equipment and implants used during my surgery. I understand that the surgeon(s) may rely, in whole or part, upon the recommendations of the representative(s) regarding the use of the involved equipment/implants.

Nursing Dept  
**CONSENT FOR OPERATION OR OTHER  
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191-111-9564 rev10/25/11 pg 1-2

Patient Label

I understand that physicians other than the operating practitioner, including but not limited to residents, may be performing important tasks related to the surgery, in accordance with the facility's policies, and in the case of residents, based on their skill set and under the supervision of the responsible practitioner. Qualified medical practitioners who are not physicians who may perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the facility.

I authorize and consent to the presence of students observing to participate in their clinical education. I authorize and consent to the presence of student participation under direct continuous guidance of my physician and his/her assistants

I certify that I have read and fully understand the above consent to operation/other invasive procedures, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in, **all statements and inapplicable paragraphs, if any, were stricken before I signed.** I have had an opportunity to ask any questions which I may have, and all of my questions have been answered fully to my satisfaction.

\_\_\_\_\_  
Signature of patient or authorized representative      Time      Date

\_\_\_\_\_  
Relationship      Signature of Interpreter (if utilized)

\_\_\_\_\_  
Signature of Witness

**TO BE COMPLETED BY PHSYICIAN:** I hereby certify that I have explained the nature, purpose and expected outcomes, benefits, risks and alternatives to the proposed procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/their representative fully understand what I have explained and agree to proceed.

\_\_\_\_\_  
Signature of physician      Time      Date

<b>Nursing Dept</b> <b>CONSENT FOR OPERATION OR OTHER</b> <b>PROCEDURE</b> 191-111-9564 rev10/25/11 pg 2-2	Patient Label
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