Bayhealth

CONSENT FOR SURGERY, AND OTHER MEDICAL SERVICES

Patient Label

PLEASE READ CAREFULLY

1. I, _____ authorize the performance of the following Surgery or Special
(**Patient Name)**

Procedure: _____

(if applicable): ☐ Not applicable ☐ Right ☐ Left ☐ Bilateral ☐ Site to be determined

_____

_____

_____

_____

(State nature & extent of operation. Spell out all words, do not abbreviate and identify side / level of procedure to be performed, if applicable).

I understand that this procedure is to be performed by/or under the direction of Dr._____ at the following Bayhealth location:_____.

I understand that licensed individuals other than my physician may participate in or perform part or all of this procedure. These individuals may include another practitioner/registered nurse, first assistant, physician assistant, resident, medical student and/or nurse practitioner. I confirm that I have had all of my questions regarding this procedure answered to my satisfaction. The individual responsible for this procedure has explained:

- The reason the treatment / procedure is recommended,
- The alternatives to the treatment/procedure (including NOT undergoing the treatment/ procedure)
- Risks related to the treatment / procedure
- Possible complications
- Possible consequences of *NOT* undergoing the treatment / procedure, and
- Potential problems related to my recovery from the treatment / procedure

NO ONE HAS MADE ANY PROMISES OR GUARANTEES RELATED TO THIS TREATMENT/ PROCEDURE

2. I understand that anesthesia may be recommended and that, if so, this will be explained to me by a person authorized to provide anesthesia.
3. I understand that tissues or parts of my body removed at surgery, body fluids, x-ray films, and other materials, as well as medical information concerning me may be used in research studies, in publication of results and in teaching. I consent to the disposal by Bayhealth Medical Center of any tissue or parts of my body which may be removed.
4. I consent to the taking and publication of any photographs and/or video for the purpose of education. In addition, I consent to the presence of observers, such as students in, the procedure room. I understand that any images, descriptions, or other information utilized for educational purposes will be de-identified.
5. I request and consent to full resuscitation, if necessary, regardless of any Advance Directive that I may have completed.
6. I understand that Bayhealth is a teaching institution. I understand that resident physicians may be performing important parts of the procedure and that the resident(s) will be supervised by one or more teaching physicians who may be out of the room for some, or all, of the procedure.

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It is very important to Bayhealth Medical Center and your physician that you understand any treatment and procedure your doctor may perform. You have a right, as a patient, to an explanation so that you can make an informed decision whether to undergo the procedure. You have the right to withdraw consent and, with this right in mind, you consent to and wish to proceed with the procedure.

Sign this form only after all discussion has taken place with you by your physician, you understand the information and all your questions have been answered.

I acknowledge that I have read and fully understand the above consent for surgery, and/or other medical services. I also acknowledge that the explanations referred to above were made to my understanding. I have not been coerced or forced into signing this form and I am signing it voluntarily stating that I want the procedure(s).

_____ _____ DATE_____TIME_____

Patient or Legally Authorized Person's Signature | Patient/Legally Authorized Person's Printed Name

_____ _____DATE_____TIME_____

If consent received by telephone, signature of monitoring witness required | Relationship to patient

Affirmation of INFORMED CONSENT by Attending Physician

I_____have informed the above-named patient, or the person authorized to extend
Clinician's Printed Name
consent on the patient's behalf, of the medical condition requiring surgical treatment and/or the further diagnostic procedures referred to above. I have explained, consistent with accepted medical judgment, the nature and purposes of the treatment or procedures and (1) the reasonable alternative methods of treatment, (2) risks, (3) possibility of complications, (4) possible results of non-treatment, (5) potential problems related to recuperation and (6) likelihood of success.

_____ Date: _____ Time:_____

Clinician's Signature

Interpreter Information (Only when Appropriate):

The information has been presented to the above-named patient in:_____(insert language). The person who provided the interpretation is a qualified medical interpreter.

_____ ___/___/___ _____

Translator Print Name & Agency ID# | Date | Time

(If using Cyracom or another telephonic or video translation service, identify the interpreter by name and agency ID# and the date and time that services were provided.