I permit Dr.________________________________ and associates or assistants selected by this physician to treat the following diagnosis or diagnoses which have been explained to me:

____

____

I understand the treatment and procedure to be:

____

____

I know about the expected result of the treatment listed above. I know that during anesthesia, the operation, the procedure, or follow-up treatment, unexpected conditions may require additional treatment. I agree that my physician and his or her assistants or designees may perform other necessary treatment in my best interest.

I know about the risk and benefit of not doing the procedure or treatment. I have been told about other forms of treatment.

I have been informed that there are significant risks related to this procedure, such as blood loss, infection, and cardiac arrest that could lead to death or permanent disability. No promise or guarantee has been made to me about the result of this treatment.

CROSS OUT ANY SECTIONS BELOW THAT DO NOT APPLY.

Both physician and patient should initial the crossed out section.

ANESTHESIA: General anesthesia, regional anesthesia, or sedation may be given to me by my attending physician, an anesthesiologist, or other qualified person as needed. I understand that there are risks related to anesthesia, such as damage to vital organs, paralysis, cardiac arrest or brain death from known and unknown causes.

TRANSFUSION OF BLOOD OR BLOOD COMPONENT: I have been informed of the risks, benefits, and alternatives to transfusion of blood components. I understand these risks to include infection, transfusion reaction, and death. I consent to the transfusion of blood components as considered necessary. I understand that this consent is valid for the duration of my hospital stay, and I can revoke my consent for blood transfusion at any time.

TISSUE: Any tissue removed may be disposed of by the hospital or physician by appropriate procedure.

**THIS FORM HAS BEEN FULLY EXPLAINED TO ME. I HAVE READ IT OR HAD IT READ TO ME.
THE SPACES HAVE BEEN FILLED IN AND I UNDERSTAND ITS CONTENTS.**

____

Patient/Responsible Person

____

Relationship of Legally Responsible Person to Patient

____________________________	__________	__________
Witness signature	**Date**	**Time**

SPECIAL CONSENT TO OPERATE OR OTHER PROCEDURES
A0009A (Rev. 11/11)