McLaren
GREATER LANSING

CONSENT TO SURGERY AND OTHER PROCEDURES

My name is (patient name) _____

My Doctor is _____

The procedure(s) which is planned is (are) _____

_____

_____

1. I request that the above listed procedure(s) be performed at McLaren Medical Center - Lansing.
2. My doctor may have other doctors assist or do part of the procedure(s). I also give my consent to the nurses and technical people at McLaren Medical Center - Lansing to do the things they usually do during such procedure(s).
3. The doctors may find something they did not expect. If this happens, the doctors may use their judgement and change the procedure(s) as necessary.
4. I know medical science is not perfect and many things are not predictable. I know I could be in McLaren Medical Center - Lansing sick or disabled, much longer than anyone expects. Nobody has given a promise or guarantee of what the results of the procedure will be. I have also been informed that in the performance of any surgical or invasive medical procedure there are risks such as severe loss of blood, nerve injury, paralysis, blood clots, heart attack, severe allergic reactions, pneumonia, infection, cardiac or respiratory arrest and death.
5. I understand that I may be given medication during the procedure and I know it is up to me to tell the doctors about allergies I have, drugs or medicines I have taken, when I have eaten or taken alcohol, any drugs or medicines I should not have and any other health problems I have. I understand it is important to my health and safety that I follow the doctors' instructions before and after the procedure.
6. I know I could lose blood. If this happens, I may need blood or products made from blood. I wish to receive blood and blood products if the doctors feel it is necessary. I understand that despite careful testing and screening of blood and blood products by collecting agencies, I may still be subject to ill effects of receiving a blood transfusion and/or blood products, including but not limited to fever and allergic reactions, hemolytic reactions, transmission of disease such as hepatitis, AIDS (HIV) and cytomegalovirus (CMV), and fluid overload.
7. I know that specimens, implants and tissues may be taken from my body during the procedure. I give permission for these to be used for teaching purposes, scientific reasons or disposed of in accordance with hospital procedures.
8. I also consent to the photographing or videotaping of any procedures or treatment to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is **not** revealed outside of the hospital by the pictures or written description accompanying them. I further consent to the presence of the technicians who are to participate in the photographing or videotaping. I waive all rights, claims, and interest in all audiovisual recordings and all rights to payment and royalties in connection with their use and/or publication.
9. I understand McLaren Medical Center - Lansing participates in educational programs of universities and other health care institutions. I also understand that my attending physician may be assisted not only by hospital employees, but persons in training from other institutions who have been given permission to do so by Ingham Regional Medical Center. I also understand that observers may be present for the purpose of education who have been given permission to observe by McLaren Medical Center-Lansing
10. My doctor has answered all of my questions to my satisfaction. I understand that if I think of any more questions, I should ask them before the procedure and my doctor will answer them.

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I have read (or have had read to me) the above "Consent to Surgery or Other Procedures," I know what it means, I request and consent to having the procedure listed above performed. I understand if I change my mind, I must tell the physician in charge of the procedure immediately and ask for this form back and place a big "X" over my signature and write my initials next to the "X".

_____ _____ Date_____ Time_____
Signature of Witness Signature of Patient

ALTERNATE CONSENT AND SIGNATURE

If the patient is too young to sign (a minor) or is not able to understand what the form means because of illness or mental condition, this section must be completed.

Name of patient: _____ Patient's age: _____

Reason patient unable to sign for self: _____
I hereby request and consent to the procedure on behalf of the patient because the patient is unable to sign for him/herself.

_____ _____ Date_____
Witness to Signature Signature of Parent or Other Person

_____
My Relationship to Patient

PROVIDER ACKNOWLEDGEMENT

I, or any physician associate, have discussed the nature, risks, benefits and alternatives of the procedure with the patient, patient's relative or other person (identified above).

_____ _____
Signature of Physician Date of Explanation