

# Carolinas Hospital System

## Consent for Operation and/or Procedure

### Acknowledgement:

I received explanation about the planned operation and/or procedure from my attending physician and/or surgeon(s). No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I understand:

- ☆ what will be performed, the risks and complications that may occur and expected recovery period
- ☆ the likelihood of success, possible benefits and drawbacks
- ☆ alternative methods of treatment and possible results of not receiving treatment
- ☆ that anesthesia, to include sedation, will be given by a person licensed by the State to give anesthesia; options risks, and alternatives have been explained to my understanding
- ☆ that there is a possibility that I could need transfusion of blood/blood products; options, risks, and alternatives have been explained to my understanding
- ☆ the professional and/or business relationship that may suggest a conflict of interest
- ☆ vendors and other Health Care providers/Students may be present during the operation/procedures if deemed appropriate by my physician

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**IF THIS PATIENT HAS AN ADVANCE DIRECTIVE, LIVING WILL, AND/OR DO NOT RESUSCITATE ORDER.**

I understand that it is the hospital policy to suspend any Advance Directive, Living Will and Do Not Resuscitate Order during the procedure and the recovery from anesthesia. I understand that I have the right to agree or disagree with this policy.

I understand and AGREE that any Advance Directive, Living Will and Do Not Resuscitate Order that I have WILL NOT BE IN EFFECT DURING THE PROCEDURE AND RECOVERY FROM ANESTHESIA.

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I understand that unexpected conditions may occur during the operation and/or procedure. In signing below, I give consent for additional or different procedures should the doctor(s) named below decide it is necessary or desirable. Exception(s): \_\_\_\_\_

(State exception(s) or "none")

### CONSENT:

I give consent for the following operation and/or procedure: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To be performed on \_\_\_\_\_, by doctor(s) \_\_\_\_\_  
(myself or name of patient)

Additionally, I give consent for the hospital to dispose of any tissue removed during the operation and/or procedure.

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Patient or Person Authorized to Care for Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Physician's Signature)