GRAND VIEW HEALTH
700 Lawn Avenue
Sellersville, PA 18960

CONSENT TO SURGERY OR OTHER PROCEDURE

1. I hereby request, consent to and authorize the performance of _____

_____

_____

_____ upon _____

by Dr. _____ and such associates and assistants as may be selected by him/her.

2. The nature and purpose of the operation or procedure, the risks and benefits involved, possible alternative methods of treatment and the possibility of complications, including the risks and benefits associated with not having the operation or procedure performed, have been explained to me by my physician, Dr. _____
3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me about the results of the surgery or procedure.
4. If any conditions are revealed at the time of surgery that were not recognized before, I authorize my physician and his/her associates to perform such additional procedures deemed necessary and desirable.
5. I consent to the participation in my care of persons training to be health care professionals. I understand that any procedure they perform will be under the supervision of a Grand View staff physician professionally qualified to perform and teach that procedure.
6. I consent to the taking and use of visual and/or sound recordings of myself in whole or in part to be used by the Hospital or its staff members for the advancement of medical education or documentation of my condition.
7. I consent to all blood transfusions deemed necessary before, during, and after the procedure or surgery.
8. I consent to the disposal, by the Hospital, of any severed tissue, implantable devices, organs or body parts which may be removed.
9. If procedure is for sterilization - I understand that I will probably be sterile as a result of this procedure, but that result **has not been, and cannot be,** guaranteed. I understand the word "sterile" means that I will be unable to conceive, father, and/or bear children.
10. I authorize the Grand View Anesthesia Associates, or their designates, to prescribe and supervise the use of such anesthetics and anesthesia techniques as they may consider advisable.
11. I understand that a technical representative from an outside company associated with the equipment being used in my procedure may be present during my operation. I consent to his/her being present to observe and to provide technical advice to the surgeon.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE FOREGOING INFORMATION ON THIS FORM, THAT THE EXPLANATIONS REFERRED TO WERE MADE, AND THAT ALL STATEMENTS THAT DO NOT APPLY TO MY SITUATION WERE CROSSED OUT BEFORE I SIGNED. I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK ANY QUESTIONS THAT I MIGHT HAVE AND THESE QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____ _____
Date Time Signature of Patient

If this consent is signed by the patient's authorized representative, the reason for this shall be inserted and the authorized person's signature shall then be witnessed.

Reason: _____

_____ _____ _____ _____
Date Time Signature of Authorized Representative Relationship

_____ _____ _____
Date Time Witness Signature

CERTIFICATION OF PHYSICIAN:
I declare that I have personally explained the above information to the patient or authorized representative and in my opinion, he/she understands what I have explained.

_____ _____ _____
Date Time Physician Signature