PHOENIX CHILDREN'S Hospital®

Consent to Operation, Procedure, Anesthetics, or Other Medical Services

Apply Patient Label

1. I authorize the following operation(s) or procedure(s) _____

   _____

   to be performed on this patient by Dr(s).____
   and the associates of his or her choice.

2. The following are true: my doctor has explained to me the nature, purpose and possible consequences of each operation or procedure, the significant risks involved, the possible complications, the expected post-operative level of functioning, the expected alterations in lifestyle or health status, and the possible alternative methods of treatment, including non-treatment. I understand that this explanation is not exhaustive, and there may be other, more remote risks and consequences.

   I know that I can have a more detailed explanation if I want, but I do not want further explanation. I have received no guarantee regarding results or outcome. I have been given an opportunity to ask questions, and my questions have been answered to my satisfaction.

3. I understand that unforeseen circumstances may arise during an operation or procedure, and may require performance of operations or procedures different from or in addition to those originally planned, in order to safeguard and promote the well-being of the patient. I consent to such other or additional surgery, procedures, or therapies as may be considered necessary or advisable by my doctors under such circumstances.

4. I consent to the use of such anesthetics as may be necessary and advisable. I understand that anesthesia may involve serious risk to the patient even when administered in a careful manner. I further understand that a patient should not drive, operate equipment or drink alcoholic beverages for at least 24 hours after anesthesia.

5. I consent to the anatomical examination and disposal by the Hospital of any tissue or body parts removed during the operation or procedure, and to the release of the patient's social security number to the manufacturer of any device implanted during the operation or procedure if federal law requires tracking of the device.

6. I know that Phoenix Children's Hospital is a teaching hospital which conducts medical and surgical teaching and training of physicians known as residents. I consent to the participation of residents in the operation or procedure identified above as approved and supervised by my doctor. I also give permission for physicians, nurses, medical students, interns, residents and other individuals participating in educational programs of the Hospital to be present to observe the operation or procedure.

SIGNATURES

I understand the procedure to be performed on my child and the risks, benefits, alternatives, and expected results of the procedure. I consent to my child undergoing the procedure that was discussed with me.

_____	_____	_____
Signature of Patient/ Patient's Legally Authorized Representative	Date	Time

_____	_____
Printed Name of Patient/ Patient's Legally Authorized Representative	Relationship to Patient

_____	_____	_____	_____
Witness Signature	Witness' Printed Name	Date	Time

(I have explained the above operation, procedure, anesthetics, or other medical services, including the risks, benefits, alternatives, and expected results, to the patient/patient's legally authorized representative named above and answered all questions to his/her apparent satisfaction.)

_____	_____	_____	_____
Practitioner Signature	Practitioner Printed Name	Date	Time

_____	_____	_____	_____
Interpreter Signature	Interpreter's Printed Name/ ID Number	Date	Time