Washington State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. **Condition: I hereby authorize Dr._____ and/or_____such associates or assistants as may be selected by my physician to perform and/or assist with my procedure(s). My physician has informed me of the nature and participation of such associates or assistants involvement in the performance of important aspects of my procedure and I consent to this. The procedure(s) being done is treatment for the condition(s) listed below which has been explained to me: *(Explain the nature of the condition(s) in professional and lay language.)***

2. **Procedure: The procedure(s) planned for treatment of my condition(s) has been explained to me by my physician. I understand it to be: *(Describe procedure(s) to be performed in professional & lay language.***

3. My physician has explained to me to the degree that I wish to have it discussed, the kind of procedure and what it will involve. I have been told about the known serious risks and complications of this procedure. Any operation or procedure involves some risks and hazards. The uncommon risks include stroke, device failure, infection, nerve injury, blood clots, heart attack, allergic reactions, respiratory failure, kidney failure, bleeding, severe blood loss, and risks of blood transfusions. These risks can be serious and possibly fatal. I have been told about other treatment options and about their risks and benefits, including not having the procedure. I have been told about what results to expect, which includes information about the chances for the expected results. I know that results cannot be guaranteed. I understand that my physician may need to perform other urgent procedures due to unexpected circumstances during my procedure. I give my permission for the physician to do so.
4. I have been informed that I will receive either anesthesia or sedation medication, or both, administered by my attending physician, anesthesiologist, or other qualified provider. I understand that there are risks and side effects associated with anesthesia and sedation, and that these risks and side effects will be discussed with me by my anesthesiologist or anesthesia provider before I have my procedure. Risks and side effects of anesthetics may involve serious possible damage to vital organs such as the brain, heart, lung, liver, and kidney and that in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes. I consent to the administration of anesthesia and/or sedation medication.
5. I consent to the use of transfusion of blood and/or blood products, as deemed necessary by my physician. I understand that all blood products involve risks of allergic reaction, fever, hives, lung injury, and in rare circumstances infectious diseases such as Hepatitis and HIV/AIDS. I understand that precautions are taken by the blood bank in screening donors and in matching blood for transfusion to minimize those risks. I have been told about other options for treatment or not getting a transfusion.

   OR,_____(patient initials) **I do not consent to blood transfusion. If refusing blood, patient must also sign "*Blood Transfusion Refusal or Limited Consent - CO12580*" form.**
6. Any tissues or parts surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.
7. In the course of this procedure I understand technology may involve imaging of the site to include photography and video. If so, this may become a part of my medical record and would be offered the same protections from disclosure.
8. My physician may also allow observers, who are not going to be assisting with my procedure including other physicians, students of healthcare programs, and suppliers of medical devices to be used in my procedure. I give permission for such observers.

I have had sufficient opportunity to discuss my condition and treatment with my physician and or their associates, and all of my questions have been answered to my satisfaction. I believe I have been given enough information upon which to make an informed decision about undergoing the recommended treatment. I have read and fully understand this form and I voluntarily authorize and consent to this operation/procedure or treatment. I understand that I am free to refuse consent to any procedure. I hereby give my consent for the above procedure(s).

Signature of Patient: _____ **Date:**_____ **Time:**_____
Or Patient's Authorized Representative & Relationship

Witness of Signature above:_____

Physicians Statement: The medical procedure or operation stated on this form including the possible risks, complications, alternative treatments, including non-treatment, and anticipated results, were explained by me to the patient/legal representative, and I have answered all the patient's questions. To the best of my knowledge, I feel this patient has been adequately informed and has consented.

Physician Signature (First Initial/Last Name/Title): _____ **Date:**_____ **Time:**_____

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