



Baystate Health System

CONSENT FOR SURGICAL OR DIAGNOSTIC PROCEDURE

1. I authorize Dr. _____ and his/her medical team to perform upon () myself or () my _____ the following procedure: (relationship)

and if any unforeseen condition arises in the course of the procedure calling for, in the physician's judgment, procedures in addition to or different from those now contemplated. I further request and authorize my doctor to do whatever he/she deems advisable. The following procedures are not authorized: if none, so state

- 2. My physician has fully explained the following to me: a) the nature of my condition; b) the nature and purpose of the procedure that I am now authorizing; c) the nature and probability of the risks involved in the procedure, including possible complications and side effects that may result; d) the benefits to be reasonably expected from the procedure; e) the likely results of no treatment; and f) the available alternatives, including their risks and benefits. My physician has also explained that, in addition to the specific risks involved in this procedure, there are other possible risks that accompany any surgical or diagnostic procedure. I acknowledge that my physician has made no guarantees or assurances to me as to the result of the procedure that I am now authorizing.
3. Further, I understand that off label use of FDA approved devices, such as stents, glues, mesh, screws, etc. may occur at the discretion of my physician. Any such use will be according to evidence based practices. I have had an opportunity to ask questions regarding off label use.
4. I understand that during or after my surgery or diagnostic procedure, I may require treatment with blood products. I understand that my doctor will follow established transfusion medicine criteria for the type and amount of blood products administered to me. I understand the risks and benefits associated with transfusion. The risks include but are not limited to febrile or allergic reactions, infectious disease transmission, and red blood cell destruction. I understand that alternatives for blood transfusion therapy may exist. These may not be readily available given my current need for surgery or diagnostic procedure, however, if my doctor believes transfusion is necessary, the likely benefits of this intervention outweigh the risks.
5. I authorize Baystate Medical Center to preserve any tissue for scientific or teaching purposes, take photographs for educational purposes, or to dispose of any remaining tissue or other matter except as noted here:

6. I have been advised that vendors/vendor representatives may be present during my procedure and I authorize their presence.

7. I certify that I have read and fully understand this consent for treatment, that the explanations referred to in this form were made, and that all blanks or statements requiring completion were filled in before I signed my name. I acknowledge that my questions about this procedure have been answered.

Patient or Person authorized to consent for patient

Witness

Date

Time

NOTE: See reverse side of this form if patient is minor consenting for him or herself

PHYSICIAN CERTIFICATION:

I certify that the above patient or responsible individual has received from me an explanation of the procedure to be performed, including the risks and benefits to be expected, and that I have disclosed alternative methods of management that might be appropriate for the patient. I have offered to answer any inquiries by this patient or responsible individual regarding the procedure.

Signed: _____

Date: _____