Beaufort Memorial HOSPITAL

Consent to Operation, Anesthetic and Other Medical Services

1. I authorize the performance upon _____of the following
   (Myself or name of patient)
   Operation/ procedure _____

   _____
   (State nature and extent of operation/ procedure to be performed)

   under the direction of Dr._____ and/ or such assistants as may be selected by him/her to perform such operation/procedure.
2. I recognize that during the course of the operation, additional different approaches or services than the procedure listed above maybe necessary. I authorize and request that the above named surgeons and/or associates, partners, assistants or designees perform such procedures if in his/her professional judgment it is necessary and in my best interest.
3. I understand the above named procedure(s) may require that I undergo some form of anesthesia; I consent to the administration of such anesthetics as may be considered necessary or advisable by the responsible anesthesia provider participating in my care.
4. I consent to the photographing or videotaping or other observation of the operation or procedures to be performed; including appropriate portions of my body, for medical scientific or educational purposes.
5. I also understand that medical, nursing and allied health students/trainees maybe present during the procedure and they observe or assist in my care, under the direction of my surgeon and other hospital staff members.
6. I consent to the presence of sales/clinical representatives during the procedure. I understand that sales/clinical representatives do not participate in the procedure.
7. I consent to the appropriate disposal (by hospital authority) of any tissue or members which may be removed during the course of the surgical procedure.
8. My physician, Dr. _____ , has explained to me the nature, purpose and possible consequences of the operative procedure that is being performed. He/she has also discussed possible alternative methods of treatment, the risks involved with this procedure and the possibility of complications that may occur. No one has made or given me a guarantee or assurance regarding the results of the operative procedure.
9. I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS OF THE AUTHORIZATION.

SIGNED:_____ DATE/TIME:_____
(Patient or Authorization Person)

_____
(Relationship to Patient)

WITNESS_____ WITNESS_____
(Witness to signature or phone consent) (Witness to signature or phone consent)

I HAVE EXPLAINED THE RISK, BENEFITS, POTENTIAL COMPLICATIONS, AND ALTERNATIVES OF THE TREATMENT TO THE PATIENT OR LEGAL REPRESENTATIVE AND HAVE ANSWERED ALL QUESTIONS TO THE PATIENT'S SATIFICATION, AND HE/ SHE HAS GRANTED CONSENT TO PROCEED.

_____ Date/ Time _____
Physician Signature

Revised: (July 2019)