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CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS, INC
601 Childrens Lane, Norfolk, VA 23507-1910

CONSENT FOR OPERATION, ANESTHETICS, OR OTHER SPECIAL PROCEDURE

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

I give authorization for the following procedure:

_____

_____

performed upon:_____(__me, __my child, __minor child)

under the direction of Dr._____ and/or the physician associates of his/her choice. Physicians in the hospital training program may participate in these operations and procedures according to standards of practice and under the supervision of the physician (s) named above.

I consent to the performance of operations and/or procedures in addition to or different from those now contemplated that the above named doctor and the physician associates may consider necessary or advisable in the course of the operation and/or procedure.

I consent to the administration of such anesthetics as may be considered necessary or advisable by the physicians responsible for this service.

I hereby authorize the administration of blood or blood products as deemed necessary by the attending physician. I understand that certain risks are involved with blood transfusions and acknowledge that such risks and alternatives to blood transfusions have been explained to me by the above named physician.

I consent to the photographing or televising of the operation or procedure performed for medical, scientific, or educational purposes.

For the purpose of advancing medical education, I consent to the admittance of observers, which may include but not limited to, Medical Students, Nursing Students, and Sales Representative in the Operating Room.

I consent to the admittance of non-medical observers in the Operating Room.

I authorize the retention, preservation, and use for scientific or educational purposes, or the disposal of any specimens or tissues taken from the patient's body during the hospitalization.

My signature below acknowledges that:
1. I have read and agreed to the foregoing statements (except those crossed out and initialed by me).
2. The proposed operation(s) and/or procedure(s), the nature and purpose of the specific treatment, the alternative methods of treatment and the risks/benefits involved have been satisfactorily explained to me by the physician. I have all the information I desire, and my questions have been answered satisfactorily.
3. I hereby give my authorization and consent.
4. I have been given no guarantee or assurance of the results that may be obtained.
5. I certify that I am the patient, the patient's parent or legal guardian and have the authority to grant this consent.

Signature: _____Date:_____ Time:_____ Relationship to Pt: _____

Date:_____ Time:_____ Witness:_____

Date:_____ Time:_____ Witness #2 :_____
(Witness #2 needed only for phone consents)

I have explained the nature, known risks, and purpose of the above operation(s) and/or procedure(s) to the patient/patient's parent or legal guardian.

Signature of Attending Physician: _____ Date:_____ Time:_____

See policy number 3102