GUAM MEMORIAL HOSPITAL AUTHORITY

Consent for Surgery/Procedures/Anesthesia/Transfusion

I, ____________________________, authorize the following operation(s) or procedure(s)
(No Abbreviations) ____

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to be performed by Dr. (s) ______________________________________and/or the associates or assistants ____________________. I understand that a representative from a medical company may be present during the surgical procedure to provide verbal technical advice to the surgeon, anesthesiologist, and/or operating room staff.

Consent to additional Surgeries/Procedures. During the course of the operation(s)/ procedure(s), unforeseen conditions may arise requiring additional surgeries or procedures to promote my well-being. **I consent** to other surgeries/procedures as may be considered necessary or advisable by my physicians under the circumstances.

Consent to Sedation/Anesthesia. I have adequate opportunity to discuss the nature, purpose, benefits, risks, side effects, and alternatives to sedation/anesthesia. **I consent** to the use of sedation/anesthesia and associated procedures as may be necessary and advisable, except ____________________________. I understand that sedation/anesthesia may involve serious risk even though administered in a careful manner. I further understand that a patient should not drive, operate equipment, or drink alcoholic beverages for at least twenty-four (24) hours after sedation/anesthesia.

Consent to administration of blood and blood products. I understand that I may need blood or blood products before or during my surgery or special procedure. I may also need it during the period of time after surgery. I understand that there are risks to receiving blood and blood products including immune/allergic reactions and some severe infections. I understand the risks of accepting blood or blood products. **I consent** to receive blood or blood products as believed needed by my physician except ______________________________.

Discussion of Risks/Benefits/Alternatives. My physician has explained the following to me:

- the nature, purpose and possible consequences of the surgery/procedure/sedation/anesthesia/ blood transfusion as well as benefits, likelihood of achieving therapeutic goals, the significant risks involved, and possible complications;
- the expected post operative function level, and expected alterations in lifestyle/health status;
- the risks and benefits of treatment alternatives;
- the risks and benefits associated with not receiving care or performing the surgery/procedure.

I further understand that the explanation I have received is not exhaustive and that there may be other, more remote risks and consequences. I have been advised that a more detailed explanation will be given to me if I so desire. I have received no guarantee or warranty concerning the results, outcome, or cure and have been given an opportunity to ask, and have answered, questions to my satisfaction.

(Continued on opposite side)

Dental Waiver. I have been advised that dental prosthetic devices including, but not limited to, dentures, bridges, caps, crowns, fillings, dental implants, etc., are more easily damaged than normal teeth. I have been advised to remove all removable prosthetic devices prior to surgery and I agree that responsibility for loss or damage will be mine if I fail to remove such dental or other prosthetic devices. I also understand that loose or damaged teeth are more prone to additional damage during the operation/procedure. I agree that responsibility for further damage to loose/damaged teeth will be mine alone.

Consent to Imaging. For the purpose of diagnosis and treatment, **I consent** to photography and videography of the operation/procedure revealing portions of my body, with the understanding that my identity will not be revealed. I understand that I may revoke this consent to imaging or the publication/dissemination of images captured at any time.

Independent Providers. I understand that some physicians performing operation/procedures, administering sedation/anesthesia, or providing services such as pathology and radiology may not be the agents, servants, or employees of the hospital nor of one another, and may be independent contractors.

Social Security Number. In the event a device is implanted during my operation(s)/procedure(s) and federal law requires tracking of the device. **I consent** to the release of my social security number for tracking purposes.

Inability to Give Consent. The patient is unable to sign for the following reason.

☐ The patient is a minor.

☐ The patient lacks the ability to make or communicate medical treatment decisions because of:

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______________________________	____________	____________
Patient's or Legally Authorized Representative's Signature	Date	Time
______________________________	____________	____________
Relationship to Patient	Date	Time
______________________________	____________	____________
Physician's Signature	Date	Time
______________________________	____________	____________
Witness' Signature	Date	Time