1. **Authorization.** I, ______________________, authorize ______________________ and any appropriate designees selected by my Practitioner, to perform the following surgery or special procedure(s) (the "Procedure"):

   Name and Description of the Procedure (must be completed by Practitioner): ________________________________________________________________

2. **Surgery or Special Procedure.** The following information has been discussed with me about the Procedure listed above: (a) the nature and intended purpose; (b) the potential risks, benefits and side effects, including any possible duration of incapacity and potential problems that may occur during recovery from the Procedure; (c) the reasonable alternatives, including the potential risks, benefits and side effects related to those alternatives; (d) the risks and consequences of not receiving the Procedure; and (e) the possible or likely results of the Procedure, including my likelihood of achieving treatment goals.

3. **Additional Procedures.** I understand that during the course of the Procedure, unforeseen conditions may arise that require additional or different procedure(s) other than the Procedure listed in Paragraph 1. I authorize and request that my Practitioner and any appropriate designees perform such other procedures as necessary in the exercise of their professional judgment. This authority extends to treating all conditions that are unknown to me at the time the Procedure is undertaken.

4. **Blood Transfusions.** I understand that I may need a transfusion(s) of blood and/or blood products in connection with the Procedure. I have been given and have read the Patient Information Sheet on Blood Transfusions, and my Practitioner has discussed with me the following information about blood transfusions:

   (a) The reason(s) I may need a blood transfusion; the nature and intended purpose; the potential risks, benefits and side effects, including any potential problems that may occur during recovery from the transfusion(s); the reasonable alternatives, including the potential risks, benefits and side effects related to those alternatives; the possible options including autologous, homologous and directed donation; any possible duration of incapacity; the risks and consequences of not receiving a transfusion(s); and the possible or likely results of the transfusion(s), including my likelihood of achieving treatment goals.

   (b) That a blood transfusion is not always successful and that no guarantee or assurance has been made to me or anyone concerning the benefits or results of a transfusion, and that I may be subject to ill effects as a result of receiving blood and/or blood products.

   (c) That this consent applies to all transfusions I may receive related to the Procedure.

**For blood transfusions, I have decided:**

(a) I **CONSENT** to receive blood and / or blood products. ☐ Yes ☐ No

(b) If I **DO NOT CONSENT** to receive blood and blood products, I understand that my refusal to have a blood transfusion may cause serious illness and possible death. I further understand that I will be offered registration in the Blood Alternative Program. ___________ (Patient must initial if refusing blood and blood products.)
Statement of Patient or Patient’s Representative. I certify the following to be true:

A. I have read and understand the information in this informed consent form.
B. The information referred to in this informed consent form has been explained to me by my Practitioner.
C. I have had the opportunity to ask and have had answered to my satisfaction all of my questions about the Procedure, including any questions about blood transfusions, anesthesia, and radiation.
D. I believe that I know enough about the Procedure to make an informed decision and that by signing below, I give my consent for the Procedure.

Patient’s Signature __________________________ Date ____________ Time ____________

Only if Patient is unable to consent, complete the following:

Name of Patient’s Authorized Representative __________________________ Relationship to Patient __________________________
Signature of Patient’s Authorized Representative __________________________ Date ____________ Time ____________

Reason Patient Cannot Consent ____________________________________________

Name of Witness __________________________ Signature of Witness __________________________

Statement of Practitioner Obtaining Consent: I certify that I have had the informed consent discussion with the patient or patient’s representative and have answered any questions related to the Procedure.

Practitioner’s Signature __________________________ Date ____________ Time ____________

Patient Information Includes: