COUNTY HOSPITAL

INFORMED CONSENT TO OPERATION, ANESTHESIA, TREATMENTS AND/OR PROCEDURES

1. Hereby request, consent and authorize Dr.________________________________and his/her assistants to perform the following procedures: ________________________________

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2. The nature and purpose of the operation and procedures with probability of success or failure, possible alternative methods of treatments, the material risks and consequences of the risks involved and the possible outcome if surgery is not undertaken have been explained to my satisfaction by my physician. I understand that no guarantees are offered as to the results of the operation, treatments, and/or other procedures.

3. I also consent to the administration of such anesthetics as necessary by surgeon or by anesthesia staff as he/she may deem advisable. The nature and purpose of the anesthesia, different type of anesthesia and its way of administration, the risk involved, and the possibility of complications have been fully explained to me. I understand the risks, alternatives and I have ample time to ask questions and to consider my decision regarding anesthesia.

4. If any unforeseen condition arises in the course of the operation or anesthesia, I further request and authorize the physician and/or anesthesia staff to perform whatever additional procedures, techniques he/she deems necessary and advisable that is in my best interest.

5. I consent to the photographing and/or video taping in course of this operation for the purposes of advancing medical knowledge. For the same purpose, I also consent to the admittance of observers to the operation room.

6. I understand that blood or blood component transfusion may be required during surgery/treatment. The risk and benefits of the transfusion as well as alternatives to transfusion have been explained to me.

7. I understand I am required to have a competent companion accompany me to the hospital and be available during and after my surgery/treatment, and I will be discharged to the person's custody and must rely on him/her for my return home.

____________________ Date and Time	____________________ Signature of Patient
____________________ Witness	____________________ Signature of Person Authorized to Consent for Patient
	____________________ Relationship to Patient