University of
at

CONSENT FOR PERFORMANCE OF OPERATION
OR
OTHER PROCEDURE AND/OR ADMINISTRATION OF ANESTHESIA

1. I authorize and consent to the performance upon myself (or) (names of patient) ____________
of the following operation or procedure: ______________________ (DO NOT ABBREVIATE)
______________________ (DO NOT ABBREVIATE)
by Dr. ______________________ or by such other physician who may be properly qualified and also available to perform the procedure.

2. I also consent to the administration of such anesthesia as may be considered necessary or desirable in the judgement of the physician or surgeon in charge.

3. I further consent to other treatments and medical procedu es which are necessarily incidental to these operations or procedures and agree that the same may be administered by qualified assistants, technicians, nurses and other personnel working under the supervision of the physician or surgeon in charge.

4. I consent to the disposal of the University of Illinois Hospital of any tissues or parts which it may be necessary to remove from my or said patient's person or body during the above mentioned operation or surgical procedure.

   I further consent a) to irrevocably donate the medical specimen(s) collected from me this date at the University of at to the Board of Trustees of the University of ("University"); b) that the University shall own the specimen(s) and may use them for research and testing purposes and may transfer the said specimen(s) to others for such purposes. I understand that my name will not be used to identify any particular specimen(s) or the outcome of any test on such specimen(s), except as necessary for my own medical treatment.

5. I consent further to photographs of my or said patient's body or portions of my or said patient's body or organs being taken during the course of any such operation or procedure if the purpose of taking the same is for the advancement of medical or surgical knowledge, and also, I consent to the use of any such photographs for such purpose. In addition, I consent to any such operation or procedure being witnessed by the students in the Health Sciences in connection with their education programs.

   The nature and purpose of the operations or procedure, possible alternative methods of treatment, the risks involved, the possible consequences, and the possibility of complications have been explained to me

   by Dr. ______________________.

   The physician's explanations were clear and understandable and I have been adequately informed about the reasons for and the effects of the procedure. I had the opportunity to ask further questions on these matters and have none now.

   (Cross out and initial any paragraphs which are not appropriate or not consented to by, or on behalf of, the patient.)

____
Signature of Patient (Or person authorized to consent for patient when patient is a minor or otherwise unable to sign in his own behalf)

____
Date of Signature

____
Relationship or basis of authority to consent

____
Address of person authorized to consent for patient

____
Signature of Witness

____
Date of Signature

____
Address of Witness

______________________ MD
Signature of Physician Obtaining Consent

____
Date of Signature

(REV 10/01) 0409