Columbia St. Mary's
A Passion for Patient Care℠

Authorization and Consent to Surgical/ Other Invasive Procedure

1. I _____ (Name of Patient) agree that I will have the surgery or other procedure(s) listed here: _____

_____

_____

_____

(Procedures to be Performed)

2. It will be done or supervised by Dr. _____ (Name of the Responsible Practitioner). My doctor may have help from others. I am aware that the people helping the doctor will only do things that they have been trained to do. They have been approved by the hospital to help the doctor.
3. My doctor has explained to me:
   a. What the procedure is and what will happen.
   b. How it may help me (the benefits).
   c. How it might harm me (the most likely and most serious risks).
   d. The long-term effects the procedure might have.
   e. My other choices for treatment.
   f. What will likely happen if I say "no" to this procedure.
   g. How I might feel right after and how quickly I can expect to feel better.
   h. What drugs will be used to sedate me, if any.
4. I agree that pictures, films, videotapes, or other records of the procedure may be taken. They may be kept with my health record or they may be used for teaching medical people or for science research at Columbia St. Mary's only. I am aware that my name will not be used on any of these items except those kept in my health record.
5. I agree that people from companies that make or sell items used in procedures may be in the room during my procedure if my doctor asks them to be there.
6. I understand that if my doctor asks or if it is needed by hospital/clinic policy, tissue removed from my body will be sent to the hospital's Laboratory to be tested. They will dispose of it when it is no longer needed.
7. I am aware that:
   a. I have the right to say "no" to this procedure,
   b. I can change my mind. If I do, I must tell my doctor or team as soon as possible.

I have read and agree to all of the above. My questions have been answered. I agree to the procedure.

Signature of Patient/Authorized Representative	Printed Name	Date/Time
Signature of Witness (to signature above)	Printed Name	Date/Time
Signature of Face to Face Interpreter – **OR** Signature of Designated Interpreter (per Waiver) – **OR** Phone or Video Interpreter ID#	Printed Name/Affiliation	Date/Time

Reference as needed:
Blood Product Administration - Consent for Administration of Blood Products
DNR-Operative/Invasive Procedure