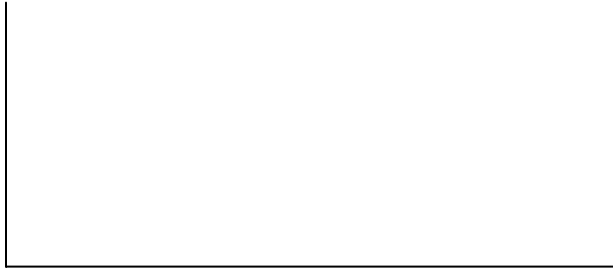




**CONSENT TO SURGICAL, MEDICAL,  
RADIOLOGICAL OR OTHER PROCEDURES**

**- NO BLOOD -**



**I. NAME OF PROCEDURE, RISKS, BENEFITS & ALTERNATIVES:**

- A. Procedure(s): \_\_\_\_\_
- B. Specific risks include but are not limited to the following: \_\_\_\_\_  
\_\_\_\_\_
- C. The procedure(s), benefits, and alternatives have been explained by: \_\_\_\_\_  
(Name of Physician/Proceduralist)
- D. The procedure(s) will be performed and/or supervised by: \_\_\_\_\_  
(Name of Attending Physician/Proceduralist)
- E. Anesthesia/sedation may be required. Risks of anesthesia (if applicable) include but are not limited to: Severe blood loss, infection, damage to teeth, mouth, throat, or vocal cords, nerve damage, eye damage, drug reaction, slowing or stopping of breathing, loss of airway, failure of the anesthetic or sedation analgesia, cardiac arrest, risks that cannot be predicted, permanent disability or even death. **[If not applicable or to be discussed by others, note in I.F. below]**
- F. Additional comments/information: \_\_\_\_\_

**II. PATIENT CONSENT TO PROCEDURE:**

- A. I authorize the Vanderbilt University Medical Center (VUMC) to diagnose and treat my condition, and I authorize its doctors, nurses, residents and other trainees, technicians, assistants, or others assigned to my case, to perform important portions of surgical, medical, radiological and/or invasive procedures.
- B. I understand my physician may request representatives from medical equipment companies to be in the room to support the use of equipment required for my procedure.
- C. The following have been explained to me: The type of operation, treatment, or other procedure and also its purpose; its expected benefits and risks, and whether my doctor advises that I should have it. Alternatives to this operation, treatment, or other procedure, if any, and the risks have been explained to me.
- D. I understand that I may require anesthesia/sedation, and if so, I authorize and consent to the administration of anesthesia/sedation.
- E. I understand that during the operation, treatment, or other procedure, unforeseen conditions may be found that make an extension of the original operation, treatment, or other procedure advisable. I authorize and agree to this extension or other operation, treatment, or other procedure, as is advisable in the professional judgment of my physician(s).
- F. I authorize and consent to the use, retention, donation or disposal of all tissues, materials, and substances that would normally be removed during the operation, treatment, or other procedure.
- G. I understand the location of my procedure or surgical incision will be identified and/or marked on my body before the procedure.
- H. I understand the explanations that have been given to me, and understand that there is no guarantee of results for the operation, treatment, or other procedure.

**III. SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE: I have read and understand this information and my questions have been answered.**

<b>SIGNATURE:</b> _____	<b>PRINT NAME:</b> _____	<b>Date:</b> _____
Patient or Legally Authorized Representative (if patient is unable to sign or is a minor)	Relationship	<b>Time:</b> _____
_____	_____	<b>Date:</b> _____
Witness (required for telephone consent or at the request of the proceduralist)	Title	<b>Time:</b> _____

**IV. SIGNATURE OF PHYSICIAN/PROCEDURALIST: I confirm that the patient/patient's representative was able to describe in his/her own words the procedure, the risks and benefits, and the parts of his/her body that will be involved.**

_____	<b>Date:</b> _____	<b>Time:</b> _____
Consent Obtained, Explained and Witnessed By (signature above)	(mm/dd/yyyy)	(Military time)

**V. RECORD NAME OF AND CONTACT NUMBER IF INTERPRETER USED: \_\_\_\_\_ **Language:** \_\_\_\_\_**