AUTHORIZATION FOR AND INFORMED CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES

1. My physician of record is Dr. _____ and my faculty supervising physician is Dr. _____ . The contact telephone number is (310) _____ .

2. This form is called an "Informed Consent." Its purpose is to inform me about the surgical, diagnostic or therapeutic procedure(s) that my physicians have recommended that I undergo. I should read the form carefully and ask questions before I decide whether or not to give my consent for the recommended operation or procedure.

3. All operations and procedures may involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. I have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternate methods of treatment and their risks and benefits. I also have the right to be informed whether my physician has any independent medical research or economic interests related to the performance of the proposed operation or procedure. Except in cases of emergency, operations or procedures are not performed until I have had the opportunity to receive this information and have given my consent. I have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance.

4. The physicians named above recommended the following operation or procedure:

   (describe the recommended operation or procedure in professional and lay language)

   Operation/Procedure - *(Professional)* _____

   _____

   _____

   _____

   _____

   _____

   Operation/Procedure - *(Lay Language)* _____

   _____

   _____

   _____

   _____

   _____

   _____

The following are significant:

Risks: _____

_____

_____

_____

_____

Benefits: _____

_____

_____

_____

Alternatives: _____

_____

_____

_____

5. The operation or procedure will be performed at **County of Los Angeles - Harbor UCLA Medical Center, 1000 W. Carson St., Torrance, CA 90509.** The hospital maintains personnel and facilities to assist physicians in the performance of the operation or procedure recommended in item number 4.

6. Upon my authorization and consent, the operation or procedure identified above, together with any different or further procedures which, in the opinion of my physician of record or faculty supervising physician or surgeon, may be indicated due to any emergency will be performed on me. The operation or procedure will be performed by Dr. _____ (or in the event that physician is unable to perform or complete the procedure by a qualified substitute, supervising physician or surgeon) together with associates and assistants from the medical staff of **County of Los Angeles - Harbor-UCLA Medical Center** to whom my physician of record of faculty supervising physician or surgeon may assign designated responsibilities.

7. If my physician determines that there is a reasonable possibility that I may need a blood transfusion as a result of the surgery or procedure to which I am consenting, my physician will inform me of this and will provide me with a brochure regarding blood transfusions. This brochure contains information concerning the benefits and risks of the various options of blood transfusions, including predonation by myself or others. I also have the right to have adequate time before my procedure to arrange for predonation, but I can waive this right if I do not wish to wait. I should understand that transfusions of blood or blood products involve certain risks, including the transmission of disease; such as, hepatitis or Human Immunodeficiency Virus (HIV) and that I have a right to consent or refuse consent to any transfusion. I should discuss any questions that I may have about transfusions with my physician.

8. By my signature below, I authorize the pathologists to use their discretion in disposing of my member, organ, or other tissue removed from my person during the operation(s) or procedure(s) indicated above.

9. I authorize the taking of photographs during the surgical procedure, with the understanding that such photographs are to be used for medical or other scientific purposes only. My identity need not be disguised or hidden; however, my name shall not be used in connection with such photographs. I acknowledge that this consent to photography is given freely and voluntarily and will not be a condition of my admission or treatment.

10. To make sure that I fully understand the information contained in this informed consent form, my physician will discuss the information with me after I have had a chance to read it and before I decide whether or not to give consent. If I have any questions I am encouraged and expected to ask them. If I think of any questions later, contact Dr. ______________________________, at (310) ______________________ who will answer them.

11. My signature below indicates that: (1) I have read or had explained to me the information provided in this form, (2) the operation or procedure set forth above has been adequately explained to me by my physician, (3) I have had a chance to ask questions, (4) I received all of the information I desired concerning the operation or procedures, and (5) I authorize and consent to the performance of the operation or procedure.

____
Signature Patient / Other Legally Responsible Person

____
Signature Witness

____
Signature Translator   Job Title

Provider Printed Last Name:	
Provider Signature:	ID#:
Date: / /	Time: : AM / PM