OCT-11-2010 15:43

SAINT BARNABAS
HEALTH CARE SYSTEM
Monmouth Medical Center

AUTHORIZATION FOR SURGICAL OR OTHER PROCEDURES

1. I, (Name of patient) _____, hereby authorize Dr. _____ and such assistants he/she may select, to perform on me, the above patient, the following procedure(s):

(Please type or print) _____

_____

2. I consent to the administration of such medications, treatments, and therapies as may be deemed advisable in the judgement of the attending physician or the designated associates of assistants.

3. It has been explained to me that during the course of an operation or procedure unforeseen conditions may be revealed that necessitated an extension of the original procedure(s) or different procedures(s) as stated in paragraph 1, above. I therefore authorize and request that the above named physician, associates and/or assisstants/residents perform such surgical procedures as are necessary and desirable in the exercise of their professional judgement. The authority granted under this paragraph shall extend to treating all conditions that are not known to the physician at the commencement of the procedure and which require treatment.

4. I am aware that medical students, manufacturers' representatives and other observers may be admitted to the operating or treatment room if approved by the physician.

5. I consent to the use and publication of photographs or videotape, in whole or in part, at the discretion of the hospital or medical staff for educational purposes. Identifying features may be visible, but I shall not be identified by name in any publications.

6. My physician has informed me, and I understand, that certain risks, complications and cconsequences are associated with this surgical/special procedure. I have received information about alternatives to the procedure. I acknowledge that no gaurantees or assurance have been made to me concerning the results. I have been given the opportunity to ask question, and all of my questions have been answered satisfactorily.

7. I further consent to the hospital's disposal of any tissues or parts, which may be removed, in accordance with the hospital's usual practice.

8. I have been informed and I understand that this consent may be withdrawn any time prior to the procedures.

_____
(Signature of patient)

_____ _____
(Signature of other responsible person authorized to consent for patient) (Responsible to patient)

_____
(Witness to signatures)

I have explained to _____ (Patient, parent or proxy) the nature of the procedure, in layman's language, the necessity for the procedure, its risks, benefits and alternatives, and the risks and benefits of those alternatives. I have also explained the risks, benefits and alternatives of recieving transfusions of blood or blood products.

_____ Date: _____
(Physician / Dentist signature)

Please fax completed form to Centralized Scheduling Office no later than 48 hours prior to surgery date.
Fax # 732-728-5100