

SPECIAL CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient: _____ Patient DOB _____

WASHINGTON STATE LAW GUARANTEES THAT YOU HAVE THE RIGHT AND OBLIGATION, AS A PATIENT, TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL, OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO THE PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU; IT IS SIMPLY AN EFFORT TO MAKE YOU BETTER INFORMED SO YOU MAY GIVE OR WITHHOLD YOUR CONSENT TO THE PROCEDURE.

I (we) voluntarily request _____ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained to me as: _____

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures:

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (WE) UNDERSTAND THAT NO WARRANTY OR GUARANTEE HAS BEEN MADE TO ME AS TO RESULT OR CURE.

_____ Patient Initial

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death.

I (WE) ALSO REALIZE THAT THE FOLLOWING RISKS, AND HAZARDS MAY OCCUR IN CONNECTION WITH THIS PARTICULAR PROCEDURE:

Worsening or unsatisfactory appearance

Creation of several additional problems, such as:

- | | |
|-------------------------------------|--|
| 1. Poor healing or skin loss | 5. Tearing |
| 2. Nerve damage | 6. Recurrence of the original condition |
| 3. Painful or unattractive scarring | 7. Others as noted on the attached sheet |
| 4. Impairment of regional organs | |

_____ Patient Initial

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risk and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (WE) CERTIFY THAT WE HAVE RECEIVED INFORMATION ABOUT OUR RIGHTS AS A PATIENT AND THOSE RIGHTS AND THIS FORM HAS BEEN FULLY EXPLAINED TO ME; THAT I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I (WE) UNDERSTAND ITS CONTENTS.

Patient/Other Legally Responsible Person _____ Date _____
PRINT NAME

Relationship of Legally Responsible Person to Patient _____

Witness to patient signature only _____ Physician's Signature _____