Rady Children's Hospital - San Diego
3020 Children's Way
San Diego, California 92123

DT70110

Consent to do Surgery or Special Diagnostic or Therapeutic Procedures

PATIENT INFORMATION

SECTION I: PATIENT/LEGAL GUARDIAN ACKNOWLEDGEMENT OF INFORMED CONSENT

I give permission to _____
(print health care provider's name) and associates to perform the following procedure/surgery:

_____

_____

My health care provider has described the proposed procedure/surgery to me and has told me about the potential risks and expected benefits, as well as other methods of treatment available and their risks and benefits, and the risks associated with refusing the recommended procedure/surgery. My health care provider has given me the chance to ask questions about the proposed procedure and all of my questions have been answered to my satisfaction. I understand that all procedures and/or surgeries involve risks of poor results, complications, injury or death from both foreseen and unforeseen causes. No warranty or guarantee has been made as to the result or cure and I understand that further treatment may be necessary in the future. I consent to the performance of the procedure/surgery noted above, in addition to any different or further procedures, which in the opinion of my health care provider, is indicated during the performance of the procedure/surgery. I understand that my health care provider may choose assistants, including resident physicians, medical students or allied health professionals, to be in attendance or assist in the performance of the procedure/surgery.

_____ (Initial if patient/legal guardian declines to be informed as to nature, purpose and risks of operation) Although I have been given an opportunity to be advised to the nature and purpose of the operations or medical procedures, the therapeutic alternatives and the risk involved, I specifically decline to be so advised, but do give my consent to the operation. No warranty or guarantee has been made as to the result or cure.

Date	Time	Signature of Patient or Legal Guardian	Relationship to Patient

Date	Time	Signature of Translator (if used)	Print Name of Translator/AT&T

Witness Verification: I verified with the patient or legal guardian that the health care provider discussed the proposed procedure/surgery, the risks and benefits, and that all the patient's/legal guardian's questions were answered.

Date	Time	Witness' signature	Print Name

SECTION II: PHYSICIAN'S / NURSE PRACTITIONER'S DOCUMENTATION

I discussed with the patient/legal guardian, the risks, benefits and alternatives to the proposed procedure/surgery, as well as the risks of refusing the recommended procedure/surgery, and answered all questions. I attest to having independently verified the patient's identity, surgical side and procedure site. I also disclosed any independent medical research or economic interests I may have related to the performance of the proposed procedure/surgery.

Date	Time	Physician's / Nurse Practitioner's Signature	Print Name