THE UNIVERSITY OF NEW MEXICO • HEALTH SCIENCES CENTER
UNIVERSITY HOSPITAL

# Authorization For a Consent To Operation(s) and Procedure(s)

MY SIGNATURE CONSTITUTES MY ACKNOWLEDGEMENT THAT

(1) I, test (Patient), CONSENT TO AND AUTHORIZE THE UNIVERSITY HOSPITAL, UNM MEDICAL CENTER, AND (none) (Attending) (none) (Fellow)

(none) (Nurse Practitioner) (none) (Resident)

OR DESIGNEE TO PERFORM THE FOLLOWING OPERATION(S) AND PROCEDURE(S) AND ANY OTHER OPERATION(S) OR PROCEDURE(S) THAT IN THE JUDGMENT OF THE PHYSICIAN MAY BE ADVISABLE ON THE BASIS OF THE FINDINGS DURING THE COURSE OF THE OPERATION(S) OR PROCEDURE(S):

(2) THE NATURE AND PURPOSE OF THE OPERATION(S) OR PROCEDURE(S) HAVE BEEN ADEQUATELY EXPLAINED TO ME BY MY ATTENDING PHYSICIAN AND I HAVE ALL THE INFORMATION THAT I DESIRE.

(3) I UNDERSTAND THAT THESE PROCEDURE(S) MAY INVOLVE CALCULATED RISK OF COMPLICATION, INJURY, AND RARE CASES EVEN DEATH FROM BOTH KNOWN AND UNKNOWN CAUSES.

(4) ALTERNATIVE MEANS OF TREATMENT AND THERAPY HAVE BEEN DISCUSSED WITH ME AND I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE THE OPERATION(S) OR PROCEDURE(S).

(5) I AUTHORIZE AND CONSENT TO THE ADMINISTRATION OF SUCH ANESTHETICS AS ARE DEEMED ADVISABLE BY THE ATTENDING ANESTHESIOLOGIST AND THE POSSIBLE COMPLICATIONS OF ANESTHESIA HAVE BEEN EXPLAINED.

(6) I UNDERSTAND THAT IF I HAVE EXCESSIVE BLEEDING DURING THE PROCEDURE, I MAY REQUIRE BLOOD TRANSFUSION(S). I CONSENT TO RECEIVING BLOOD TRANSFUSION(S) IF NECESSARY. THE BENEFITS AND POTENTIAL RISKS OF BLOOD TRANSFUSION HAVE BEEN EXPLAINED TO ME.

(7) NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.

(8) I REQUEST THAT ANY TISSUE, ORGAN, OR MEMBER SEVERED IN ANY OPERATION BE DISPOSED OF BY THE PATHOLOGIST IN A MEDICALLY ACCEPTABLE MANNER.

(9) I CERTIFY THAT I HAVE READ OR HAD READ TO ME THIS AUTHORIZATION AND CONSENT, THAT ALL BLANKS REQUIRING COMPLETION WERE FILLED IN BEFORE I SIGNED AND THAT I UNDERSTAND AND AGREE TO THE FOREGOING.

DATE: _____

TIME: _____

X _____
Patient, Person Authorized to Consent

_____
Relationship

_____
Witness

_____
Interpreter (if utilized)

THE UNDERSIGNED PHYSICIAN HEREBY CERTIFIES THAT HE/SHE HAS EXPLAINED TO THE ABOVE-NAMED PATIENT OR OTHERWISE AUTHORIZED CONSENTING PERSON ALL OF THE MATTERS ABOVE REFERRED TO; AND THE EXPLANATION IN HIS/HER PROFESSIONAL JUDGMENT WAS ADEQUATE AND REASONABLE.

**TEST**
**MR#:** 00000 000000100
**DOB:** 01/01/19 **AGE** 02 Years
**DOE:** 12/14/06

*00000000000100*

_____ _____
Physician Signature Date / Time