Loyola University Medical Center
Consent for Surgery

Name:

MR#:

1. I hereby authorize Dr. David A. Hatch, attending physician, and such assistants and associates as may be elected by him to perform the following procedure(s) upon: ____________________________

   Procedures: __________ Circumcision (making an incision around the foreskin to remove it and then sewing the skin edges together with dissolving sutures) ____________________________

2. I understand that this procedure(s) appears to be indicated by the diagnostic studies and/or clinical observations already performed regarding the following condition:

   Condition requiring the procedure(s): _______ Phimosis/parental desire ____________________________

3. I authorize the administration of anesthesia as may, in the exercise of good professional judgment, be necessary or advisable by the physician responsible for administering anesthetics.

4. I authorize the administration of blood and blood products as may be considered necessary or advisable in connection with the procedure(s) described above.

5. The nature, purpose, and possible complications of the procedures and medical services described above, the risks and benefits reasonably to be expected, and the alternative methods of treatment have been explained to be by my physician. I understand the explanation I have received.

   Possible Complications: _______ Bleeding (1/200-300), Infection (very rare), Removing too little skin (rare), Removing too much skin (very rare), others ____________________________

6. I recognize that during the operation unexpected conditions may be revealed which require my doctors to perform additional or different procedures than those described above. I hereby authorize and request the physician performing these procedure(s) and his assistants or designees perform such other procedures as are, in the exercise of good professional judgment, necessary and desirable. I understand that these procedures may include surgery as well as other forms of treatment. The authority granted in this paragraph shall extend to remedy all conditions found during the operation that require treatment, and that are not known at the time the procedure is commenced.

7. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure.

8. I consent to the photographing or televising of the procedure to be performed, including appropriate portions of the patient’s body, for medical, scientific, our educational purposes, provided the patient’s identity is not revealed by the pictures or by descriptive texts accompanying them.

9. For the purpose of advancing medical education, I consent to the participation of house staff and medical students in the procedure.

10. I consent to the admittance of observers, technical assistants or representatives of equipment or device manufacturers who may provide technical support during performance of the procedure.

11. I consent to the disposal by hospital authorities of any tissues or body parts that may be removed.

12. I acknowledge that I have read this document in its entirety and that I fully understand it, that all blank spaces have been completed and that any disagreeable sections have been crossed off, prior to my signing.

Consenting Party:

__________________________  ____________________________  ____________________________  ____________________________
Date                        Time                        Print Name                        Signature

Witness:

__________________________  ____________________________
Print Name                        Signature
AFFIRMATION OF INFORMED CONSENT BY PHYSICIANS

I do affirm that I have informed the above-named patient or the patient’s authorized representative, of the condition requiring surgical treatment and diagnostic procedures referred to above and that I have, consistent with my best medical judgment, fully explained the nature and purposes of all the treatment and procedures consented to in the above consent form, possible alternative methods of treatment and procedures, the risks involved and the possibility of complications in the treatment and procedures consented to and in alternative treatments and procedures, and that, after the foregoing information had been explained, the patient or representative indicated that he/she understood that information and consented to such treatment and/or other procedures described in the above consent form.

Date  David A. Hatch, M.D.

INTERNPRETER

I do hereby affirm and certify that I acted as interpreter for the patient or the patient’s representative and accurately and completely translated into the _________________________ language both the statements contained on this form as well as the statements made by the physician, Dr. David A. Hatch, to the patient and/or the patient’s representative and that the patient or the patient’s representative stated that he or she understood all of the statements and consented to the treatment and/or other procedures described in those statements.

Date  Signature