Bastian Voice Institute
*for voice, swallowing & airway disorders*

# CONSENT: SURGERY OR SPECIAL PROCEDURE

1. I hereby authorize Dr.______________________Attending Physician(s) or such assistants and associates as may be elected by him/her to perform the following procedure(s) upon:

   Patient Name:_____________________________________________________

   Procedure(s):_____________________________________________________

   __________________________________________________________________

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

   Condition requiring the procedure(s):___________________________________

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. The nature, purpose, and possible complications of the procedure(s) and medical services described above, the risks and benefits reasonably to be expected, and the alternative methods of treatments have been explained to me by my physician. I understand the explanation I have received.

5. I recognize that during the procedure unexpected conditions may be revealed which require my doctors to perform additional or different procedures than those described above. Since I may be under anesthesia, I hereby authorize and request that the physician performing these procedure(s) and his assistants or designees perform such other procedure(s) 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 procedure that require treatment and that are not know at the time the procedure is commenced.

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

7. I consent to the photographing or televising of the procedure(s) to be performed including appropriate portions of my body for medical, scientific or education purposes, provided my identity is not revealed by the pictures or by descriptive accompanying them.

8. For the purpose of advancing medical education I consent to the participation of house staff and medical students in the procedure and to the admittance of observers to the room in which the procedures is performed.

9. I consent to the disposal by Bastian Voice Institute authorities of any tissues or body parts which may be removed.

10. 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 me signing.

Date:_______________________________________Time:_________________________

Patient Signature:___________________________________________________________

If consenting party is other than patient:________________________________________
Print Name

______________________________________________
Signature/Relationship

*Witness:*

________________________________________________________
Signature

________________________________________________________
Printed Name

**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 judgment, fully explained that the nature and purposes of all the treatment and procedure, the risks involved and the possibility of complications in the treatment and procedure consented to and in alternative treatment 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.

_______________________________________, M.D. Date:____________________

**INTERPRETER**

I do affirm and certify that I acted for the patient or in 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.____________________________, to the patient or the patient's representative and that the patient or the patient's representative stated that he or she understood all of these and consented to the treatment and/or other procedures described in those statements.

__________________________________________
Signed

__________________________________________
Date