GBMC
6701 North Charles Street
Baltimore, Maryland 21204

CONSENT TO DIAGNOSTIC, OPERATIVE, THERAPEUTIC, BLOOD TRANSFUSION AND PHARMACOLOGICAL PROCEDURE

Date of Procedure: _____

Name of Patient: _____(type or print.)

1. I consent to the performance of the following upon the Patient, under the direction of Dr. _____, as the healthcare provider in charge; these procedures may be performed by him/her or anyone whom he/she may designate:

   (a) Physical examinations, other routine diagnostic procedures and routine medical treatment;

   (b) The following operative, special diagnostic or therapeutic procedures:

   _____

   _____

   (c) The injection or other administration of the drugs or other substances incidental to any procedure described in subparagraphs (a) or (b) above.

   (d) Any other procedure related or incidental to those enumerated above, if within a reasonable degree of medical certainty the procedure is necessary to avoid a substantial risk of death or immediate and serious harm to my health, and someone authorized to give consent on my behalf is not reasonably available to make the decision.

   (e) At the option of my health care provider, the videotaping or photographing of any surgical procedure for diagnostic purposes or for educational or research use under circumstances in which my identity will be protected from disclosure to persons not otherwise involved in my care.

2. The health care provider has explained the benefits, alternatives (including not having the procedure(s)), and major risks to me so that I understand. These include but are not

NOTE: THIS IS A TWO SIDED FORM.

limited to bleeding, infection (wound, urinary, other), heart attack, stroke, pneumonia or respiratory failure, kidney failure, blood clots, nerve damage, or even death. Other specific risks include:

_____

_____

3. I consent to the study, use and disposal by GBMC authorities of any tissue or parts that may be removed.

4. I consent to the administration of blood and blood products, if required, by any person qualified to do so. I understand that blood or blood products may be needed to correct anemia, replace blood lost during a procedure or to help my blood clotting. Uncommon reactions may include chills, fever or a rash. Rare but more serious conditions may be heart, kidney or other organ failure, a reaction due to blood incompatibility or acquiring an infectious disease such as Hepatitis or HIV (AIDS.) These procedures, possible alternatives such as autologous donations (donation of my own blood prior to a procedure), and their respective risks and benefits have been explained to my satisfaction.

5. No warranty or guarantee has been given to me by anyone as to (a) the results of the procedures in Paragraph 1, or (b) the fitness or quality of any drug, anesthetic, blood or blood product or other substance to be used in those procedures.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE WITH WHAT IT SAYS

_____ _____

(Witness Signature) (Patient Signature)

_____ _____

(Print Name) (Print Name)

_____ _____ _____ _____

(Date) (Time) (Date) (Time)

_____

(Other Authorized or Required to Consent)

_____

(Relationship to Patient)

_____ _____

(Date) (Time)

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