DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

(A) The following surgical or diagnostic procedure(s) (the "Procedure(s)") is/are to be performed at a SGHS Facility (South Georgia Medical Center, SGMC Berrien Campus or SGMC Lanier Campus, collectively referred to in this document as "SGMC") by

Dr. ______________________________ (the "Doctor"): ______________________________

____

____

(B) **I have been informed of the following:**

(1) That a physician(s) other than the Doctor will be performing the following important tasks related to the Procedure(s) within his/her scope of practice and SGMC privileges:
____; and

(2) The following tasks related to the Procedure(s) may be performed by medical practitioners who are not doctors (physician's assistants or advanced practice registered nurses) within their scope of practice and SGMC clinical functions:
____

(C) I hereby permit the Doctor and such other physician(s), practitioners or persons as are needed to assist him/her to perform the Procedure(s) on me. I also hereby permit manufacturer's representative(s) and/or vendor(s) (who are not employees or agents of SGMC) to be present during the Procedure(s) in order to advise or assist the Doctor(s) regarding the application of surgical device(s) or technology(ies), and to be involved in calibration or adjustment of medical devices to the Doctor(s)' or manufacturer's specifications.

(D) **(Initial only one option)**

________ I have been informed of the nature of the Procedure(s) and how it is generally carried out. I have been informed of the material risks and possible side effects of the Procedure(s) including, infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death. I have also been informed of:

(1) A diagnosis of my condition requiring the Procedure(s);
(2) The nature and purpose of the Procedure(s);
(3) The likelihood of success of the Procedure(s) and whether the Procedure(s) will achieve my treatment goal(s);
(4) The likelihood of experiencing a material risk or side effect of the Procedure(s);
(5) The practical alternatives to the Procedure(s) and the risks, benefits and side effects of such alternatives;
(6) My prognosis and possible results if the Procedure(s) is/are rejected;
(7) The potential benefits or side effects of the Procedure(s), including potential problems related to recuperation;
(8) Limitations, if any, on the confidentiality of information learned about me;
(9) The nature, purpose, and risks of anesthesia or procedural sedation, if applicable; and
(10) Other: ____

________ I acknowledge that I have a right to receive information about the Procedure(s), including the topics listed above. Having full knowledge of this right, I fully and completely waive the right to be given this information and do hereby release the Doctor and SGMC, or any of their employees or agents, from any liability which could arise from failing to provide me this information.

(E) No guarantees have been made to me that the Procedure(s) will improve my condition.

(F) I understand that it may be necessary to administer blood and/or blood products during the Procedure(s). I understand that blood and blood products are currently tested and screened for the presence of potentially transmissible infectious agents according to standards established by the Food and Drug Administration and the American Association of Blood Banks. I also understand that the current screening of donated blood does not eliminate the potential transmission of every harmful infectious disease.

(G) I acknowledge and understand that during the course of the Procedure(s) conditions may develop which may reasonably necessitate an extension of the Procedure(s) or the performance of additional procedure(s) that are unforeseen or not known to be needed at this time. I also understand that unforeseen conditions may develop that may require involvement of additional physicians and practitioners not named above.

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ACKNOWLEDGEMENT OF INFORMED CONSENT FOR SURGICAL OR DIAGNOSTIC PROCEDURES

DOB

(H) I have been given ample opportunity to ask questions and discuss the Procedure(s). Questions I have asked have been answered or explained in a satisfactory manner.

(I) I understand that some or all of the health care professionals performing services in SGMC are independent contractors and are not SGMC agents or employees. Independent contractors are responsible for their own actions and SGMC shall not be liable for the acts or omissions of independent contractors.

(J) I have been informed that the discovery of certain medical conditions, such as HIV, venereal disease, tuberculosis, and any other specified by law, may require the Doctor and/or SGMC to disclose patient information to the Georgia Department of Community Health or other regulatory health agency.

(K) I acknowledge and understand that if I have consented to a Do Not Resuscitate (DNR) Order, it will be suspended during the pre-operative, operative and recovery periods of the Procedure(s).

(L) If I am acting on behalf of the Patient, I acknowledge that I am obligated to act in good faith to consent only to surgical or medical treatment or procedures which the Patient would have wanted had the Patient understood the circumstances under which such treatment or procedures were provided.

(M) By signing below, I acknowledge that I have read or had the above explained to me and voluntarily consent to the Procedure(s).

____

______________________________	______________________________
Printed Name of Patient or Person Authorized to Consent for Patient	**Signature of Patient or Person Authorized to Consent for Patient**

Date: ____________________ Time: __________ am / pm

Complete if signed by person other than the patient:

Relationship to Patient[1] (Choose only one):

☐ Health Care Agent	☐ Sibling	☐ Parent	☐ Grandparent	☐ Spouse
☐ Grandchild	☐ Guardian	☐ Adult Child	☐ Adult Friend	☐ Aunt, Uncle, Niece, or Nephew

Reason Patient Incapable to Sign: ______________________________

______________________________	______________________________
Printed Name of Physician/Practitioner	**Signature of Physician/Practitioner**

Date: ____________________ **Time:** __________ **am / pm**

Complete the following if an Interpreter was utilized:

______________________________	______________________________
Interpretation Service	Name of Interpreter

[1] See SGHS Policy, *Who May Consent to Medical Treatment* to determine whether a person is authorized to consent for a patient.

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