UCLA Health

MRN:
Patient Name:

(Patient Label)

CONSENT FOR SURGERY OR SPECIAL DIAGNOSTIC or THERAPEUTIC PROCEDURE(S)

1. I agree to have Dr. [name] _____("Surgeon"), and any associates or assistants selected by Surgeon to do the following operation(s) or procedure(s) ("Procedure") on the patient named above ("Patient"):

   _____

   _____

   _____

2. All Procedures have risks, including bleeding, infection, and even death.

   I have been informed of such risks, as well as the nature of the Procedure, the likelihood of achieving goals, the expected benefits or effects of such Procedure, including side effects and potential problems that might occur during recuperation, and the reasonable alternative methods of treatment and their risks and benefits. I have also been informed of the consequences of declining the Procedure and the reasonable alternatives.

3. I agree to have additional procedures if, during the Procedure, my Surgeon decides they are needed for reasons not known before the Procedure. I also authorize my Surgeon to provide or arrange for the provision of additional services, as necessary or advisable, including but not limited to, pathology and radiology services.

4. UCLA is a teaching institution. Resident physicians and students may work with the surgeon. Resident physicians may do part of the surgery. The Surgeon will decide at the time of the surgery which residents will take part. What they are allowed to do will depend upon their skill and the Patient's condition. Residents will be under the supervision of the Surgeon. There are times when an attending Surgeon will oversee the care provided by teams in two operating rooms simultaneously, defined as concurrent staffing. The Surgeon or an attending designee will be present for all the critical parts of the procedure/ surgery. The Surgeon may be out of the operating room for some or all of the surgical tasks done by residents if the Surgeon decides it is safe to do so.

5. Trained licensed people who are not physicians may do part of the surgery or administer the anesthesia. They will be only doing things allowed by the hospital and by law.

6. My Surgeon may have health care industry representatives or other visitors present in the operating room for technical support related to my treatment, and I authorize those individuals to be present.
   ☐ I DO NOT authorize those individuals to be present.

7. My Surgeon does not have any financial or research interest in the Procedure, (including but not limited to a consulting or services agreement, or receipt of research funding) with a vendor of any products or devices used in the procedure, other than his/her professional fees, unless noted below:

   _____(initial if applicable) My Surgeon has informed me that he/she has a financial relationship with a vendor of products or devices used in the procedure.

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8. UCLA may keep, use or dispose of anything removed during the Procedure ("Specimens"). Specimens may be used for research. I do not own the Specimens, or data derived from Specimens, and have no right to any research or research product using or derived from the Specimens. Specimen includes, but is not limited to, any tissues, organs, bones, bodily fluids, or medical devices.
9. I have the right to consent to or to refuse any proposed operation or procedure, including the Procedure, at any time prior to its performance. I am aware that the practice of medicine and surgery is not an exact science, and no guarantee has been made as to the results of the Procedure or any cure. I also understand that the explanations that I have received may not be exhaustive or all-inclusive and that other more remote risks may be involved. However, the information that I have received is sufficient for me to consent to the Procedure. I have had a full opportunity to ask questions concerning my condition, the Procedure, the risks, and the alternatives. All of the questions that I have asked have been answered to my satisfaction.
10. I understand that if an implantable device is used, information regarding the device and my Social Security Number may be reported to the device manufacturer, if requested, and as required by Federal law.

1) I have read and understood the information contained here;
2) I have been informed about the Procedure and the potential risks, benefits, alternatives and the risk of those alternatives;
3) I authorize and consent to the performance of the Procedure as described; and
4) I authorize and direct that any Specimen removed during the Procedure is to be handled as indicated above.

Signature of patient, parent or conservator | Date | Time

If not signed by patient, indicate relationship or guardian

Witness to Signature | Printed Name of Witness to Signature

Date | Time

I have discussed the above information with the patient.

Physician Signature | Date | Time

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I have accurately and completely read this consent to (patient or patient's legal representative) in the patient's or legal representative's primary language _____ (identify language). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Signature of Translator	Printed Name of Translator

Date	Time	Translator ID #