



CONSENT FOR OPERATION AND/OR PROCEDURE

I hereby give consent to Dr.(s) _____,

(Name(s) of Attending Surgeon(s)/Physician(s))

and Hospital for Special Surgery and its staff (including residents and fellows) providing such surgical and other related procedures, and therapeutic services, as they may consider necessary, to include the following operation and/or procedure using the named implant/implant system (if any):

**PATIENT VERIFICATION OF
SURGICAL SIDE**

Left Right Bilateral
Anterior Posterior

Patient's Initials _____

(description of operation and/or procedure, including name of implant/implant system to be used, if applicable)

to/upon _____.

(Name of Patient)

The surgeon(s) and/or physician(s) named above have explained to me and discussed with me the nature, intended purpose, anticipated benefits, material risks, and possible complications of such operation/procedure, the alternative therapies if the above operation/procedure is not performed, and the probable consequences if such operation/procedure or alternative therapies are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the operation/procedure may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with surgery, use of medication, medical procedures and treatments which can cause adverse consequences not ordinarily anticipated in advance.

I understand that during the course of the operation/procedure, unforeseen conditions may be revealed or encountered, and that surgical or other procedures in addition to or different from those described above may be necessary or desirable to address those conditions. I also understand that the above named surgeon/physician may choose to use an implant/implant system different from the one specified above, or none at all, depending on the circumstances. I consent to the above named surgeon(s)/physician(s) or his/her designee(s) performing on me/the patient such additional surgical or other procedures, and using such alternative implants/implant systems, as they deem necessary or desirable.

I understand that due to unforeseen scheduling or other reasons, the above named surgeon(s)/physician(s), other than the attending surgeon/physician, may not be available to treat me/the patient. I therefore give permission to Hospital for Special Surgery to assign other surgeons/physicians to treat me/the patient.

I understand that some important surgical tasks may be performed by practitioners other than the surgeon(s)/physician(s) named above, and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under New York law, and privileges granted by the Hospital, and will be performed under the supervision of the surgeon(s)/physician(s) named above. Post-graduate physicians (residents and fellows) and qualified medical practitioners who are not physicians (physician assistants and specialist assistants) may open and close, dissect tissue, remove tissue, harvest grafts, and place invasive lines. In addition, post-graduate physicians (residents and fellows) may implant devices and transplant tissue.

I grant permission for the Hospital to use for medical, scientific, and/or educational purposes any tissues, organs and hardware (including implants and instrumentation) removed from me/the patient during the operation/procedure. I consent to the disposal by the Hospital of any such tissues, organs and hardware in accordance with its customary practice.

I consent to the photographing, videotaping, televising, or other observation of the operation/procedure as the Hospital or the above named surgeon(s)/physician(s) may deem useful or appropriate for scientific, and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the operation/procedure of a visitor or visitors, which may include a visiting physician and/or a vendor representative whose presence has been requested by the above named surgeon(s)/physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other Hospital personnel, and subject to all relevant Hospital policies and procedures.

I confirm that I have read and fully understand this document, that I have been given the opportunity to ask questions about the operation/procedure and have had my questions answered satisfactorily, and that I am eligible to give this consent.

Signature of Patient/Parent/Guardian/ _____ **Date** _____ **Time** _____
/Health Care Agent
Relationship to Patient _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this Consent for Operation/Procedure.

Signature of Witness _____ **Date** _____ **Time** _____

Surgeon(s)/Physician(s) Certification(s): I certify that I have explained to and discussed with the person whose signature appears above the nature, intended purpose, anticipated benefits, material risks, and possible complications of the operation/procedure specified above, the alternative therapies, and the probable consequences if the above operation/procedure or alternative therapies are not performed.

Signature of Surgeon(s)/Physician(s) _____ **Date** _____