Patient's Name: _____

Name(s) of Physician(s)/ Practitioner(s) Performing Operation Or Procedure, or Important Aspects of the Operation/Procedure:	Name and Description of Operation or Procedure, or Important Aspects of the Operation/Procedure: (No abbreviations)

1. I authorize the above-named physician(s) practitioner(s) and any assistants that he/she may select (collectively, "my Physician(s)"), to perform the above-described procedure or operation on me at Littleton Regional Hospital.
2. I understand that, during the course of the procedure or operation, a condition may arise or be discovered that my Physician(s) did not or could not have anticipated, and in that case, I consent to the performance of operations or procedures in addition to or different from those now contemplated which my Physician(s) may consider necessary or advisable to protect my life or health. I agree to the administration of blood and/or blood products, if such treatment becomes necessary during or within 72 hours of my operation or procedure.
3. I consent to the administration of such anesthetics and sedation, either intravenously or otherwise, as may be considered necessary or advisable by the responsible physician(s) practitioner(s) during the procedure or operation. I understand that there are certain risks to receiving anesthesia/sedation, including but not limited to, adverse reactions, neurological complications, respiratory distress, cardiac arrest, or death.
4. I understand that if certain surgical products or medical devices are required for my procedure, staff from that company may be present to provide technical assistance to the procedural team.
5. I authorize the examination and disposal of any tissues, organs, other body parts, foreign objects or other specimens that may be removed during the course of this procedure or operation, under the direction of Littleton Regional Hospital's Chief of Pathology.
6. I consent to Photography or videotaping, under the direction of my Physician(s), of the procedure and/or specimens, for purposes of medical education and/or anonymous publication.
7. The nature and purpose of the operation or procedure named above, likely benefits, reasonable alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I understand that the practice of medicine and surgery is not an exact science, and I agree that no guarantees or assurances have been made to me about the results of this procedure or operation. I understand that it is impossible for physician(s) practitioner(s) to predict and disclose all of the possible risks or complications of the proposed procedure.
8. If I have a Do Not Resuscitate Order, I have been given an opportunity to advise caregivers of my intent if life saving treatment is needed during this procedure.

I have read the information on this form (or have had read to me). I have had an opportunity to ask questions and have had them answered to my satisfaction. I understand and agree to all of the terms above. I certify that I am the patient or the parent's legal representative with authority to sign this document on the patient's behalf.

_____ Date: _____ Time: _____AM/PM__

Signature of patient/parent/agent under durable power of Attorney for Health Care/Legal Guardian (Circle one)

_____

Witness signature

I have explained to the above-named patient/consenting party the proposed operation or procedure, including its nature and purpose, the likely benefits, the possible risks and complications involved, the reasonable alternative methods of treatment, and the consequences of the failure to undergo such procedure or operation.

_____

Signature of Physician/Practitioner

Physician/Practitioner please indicates, if applicable:
Patient is unable to sign because: O Minor O Temporarily incapacitate O Permanently incapacitated

Littleton Regional Healthcare
600 St. Johnsbury Road
Littleton, NH 03561

Patient Identification

CNT

We, the undersigned, certify that _____
(Name of legally authorized consenting party)

Has been informed about the nature and purpose of the proposed operation or procedure, including the likely benefits, reasonable alternative methods of treatments, the risks involved, and the possibility of complications. We also certify that he/she has agreed to the terms stated on this Informed Consent – Operative Form. (Read over telephone to individual giving consent.)

Name of Legally Authorized Representative:
_____
Telephone number representative reached at:
_____
Relationship to patient: O Parent O Legal Guardian O Agent under Durable Power of attorney for healthcare

Reason for obtaining consent via telephone:
_____
Date and Time consent obtained:
_____
Consent read to representative by: Signature:
_____
Telephone conversation witnessed by: Signature:
_____

We, the undersigned, deem the case of the patient named hereon to be an emergency.

Physician Signature: _____M.D. Physician Signature: _____M.D.