METHODIST MEDICAL CENTER OF ILLINOIS
CONSENT TO SURGERY, ADMINISTRATION OF ANESTHETICS OR OTHER PROCEDURES

Patient's Name: ____

Physician's Name: ______________________________ or other physicians associated with him/her in practice and such assistants as may be designated by him/her to perform upon the following described procedure:

Surgical Procedure: ____

____

____

My physician has fully explained to me or my legal representative:

- the nature of the procedure(s) to which I am consenting and recovery after surgery in a manner that I understand;
- the major risks and possible complications of this/these procedure(s) including such risks as severe loss of blood, side effects, infection, stopping of my heartbeat, and death which are associated with the performance of any surgical procedure; any optional treatments or procedures and risks, advantages and disadvantages associated with each of the optional procedures; the nature and length of any likely disability I may be expected to have following this/these procedure(s);
- that a resident may participate in my procedure, the extent of the resident's participation and I have agreed to the resident's participation;
- that qualified medical professionals who are not physicians (physician assistants or advanced practice registered nurses) may be performing important parts of the surgery or the giving of anesthesia and would only perform those tasks that are within their scope of practice or privileges granted, as determined by state law and hospital policy.

I consent to the:

- entering of authorized personnel, technical representative and observers including students to the operating room;
- giving of such anesthetics as may be considered necessary or advisable by the physician responsible for this service. I have been informed of the nature of anesthetics, where in my body they are given, their usual effects and the risks associated with their use; and
- photographing, videotaping, or other digital recordings, or televising of the operations or procedures to be performed including necessary portions of my body for medical, scientific or educational purposes. I understand that my identity will not be revealed and I have the right to request the stopping of any recording or filming. I consent to the disposal by The Methodist Medical Center of Illinois of any tissue or body parts, which may be removed, in accordance with its policies.

I understand that:

- unforeseen problems may be found during the procedure which, in the opinion of my physician, may require treatment in addition to or different from those described above. If that occurs, I request and authorize that the physician provides the additional procedure or treatment.
- the practice of medicine and surgery is not an exact science and I accept that no guarantee or assurance has been given to me by my physician or any other person about the results of the operation or procedure(s).
- the physicians and physician assistants giving care to me, including but not limited to all physicians and physician assistants staffing the Methodist Emergency Department; radiologists; pathologists; cardiologists; neurologists; surgeons; and certain other specialists and physicians giving care to me are not agents or employees of Methodist Medical Center of Illinois unless exactly stated by the Hospital, and the employment or agency status of the physicians treating me did not enter into my decision to select Methodist Medical Center of Illinois for my care and that Methodist Medical Center is not legally responsible for them as such, and their practice of medicine is independent from Methodist Medical Center's control. These independent physicians and physician assistants may be employed by but not limited to the following medical groups: Peoria Obstetrics & Gynecology Group, S.C.; Comprehensive Emergency Solutions, S.C.; Central Illinois Radiological Associates, LTD; and Peoria-Tazewell Pathology Group, S.C.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT; ALL BLANKS HAVE BEEN FILLED IN; I HAVE RECEIVED ALL INFORMATION THAT I DESIRE AND ALL MY QUESTIONS HAVE BEEN ANSWERED; AND AFTER THAT I HAVE SIGNED AND DELIVERED THIS CONSENT AS MY FREE AND VOLUNTARY ACT.

______________________ ____________ ____________

Signature of Patient (Date) (Time)

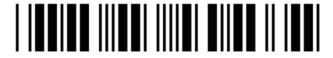
PHYSICIAN CERTIFICATION

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with the patient (or the patient's legal representative), including: risks and benefits of the procedure; any adverse reactions that may reasonably be expected to occur; any alternative methods of treatment, side effects, potential problems that may occur during recuperation; the likelihood of achieving treatment goals; and that any and all of the patient's questions have been answered.

______________________ ____________ ____________

Signature of Physician Date) (Time)

PATIENT STICKER



EXECUTION (ACTION) BY PARENT OR RESPONSIBLE ADULT

In that the patient ____________________________ is (a minor) (an adult who is unable to give his/her consent because he/she is): ____

____*.

I, ____

the, (relationship)____

of said patient state that I have read the above Consent to Surgery, Administration of Anesthetics or Other Procedures and agree that the explanations given there have been personally made to me and I give this consent on the patient's behalf.

__________________________________ ___________ ___________
Signature of Parent or Responsible Adult (Date) (Time)

__________________________________ ___________ ___________
Signature of Witness (Telephone Consent) (Date) (Time)

***State reason such as unconscious or lack of decisional capacity.**

PATIENT STICKER