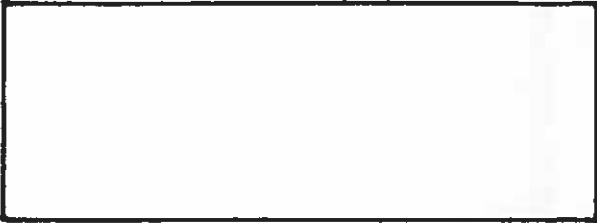


**Holy Cross Hospital
Taos, New Mexico**



**Informed Consent for Operations/Procedure
including Blood And Blood Products**

1. I give permission to Dr.(s) _____ to perform the following procedure(s)

2. I understand that during the procedure(s), new findings or conditions may appear and require an additional procedure(s) for proper care.
3. My physician has explained the following items:
 - the nature of my condition
 - the nature and purpose of the procedure(s) that I am now authorizing
 - the possible complications and side effects that may result, problems that may be experienced during recuperation and the likelihood of success
 - the benefits to be reasonably expected from the procedure(s)
 - the likely result of no treatment
 - the available alternatives, including the risks and benefits
 - the other possible risks that accompany any surgical and diagnostic procedure (in addition to those already discussed). I acknowledge that neither my physician nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the procedure(s) that I am now authorizing.
 - that other associate(s) _____ may help my physician, or perform certain aspects of the described procedure(s) such as:

4. Any tissue or specimens taken from my body as a result of the procedure(s) may be examined and disposed of, retained, preserved, or used for medical, scientific or teaching purposes by the hospital.
5. I understand that my procedure(s) may be photographed or videotaped for the purpose of advancing medical care and education, provided my identity is not revealed by the pictures or by the descriptive text accompanying them, I also understand that observers may be present in the room.
6. I understand that during or after the procedure(s) my physician may find it necessary to give me a transfusion of blood or blood products. My physician has explained the alternatives to, and possible risks of transfusion.
7. I understand what my physician has explained to me and have had all my questions fully answered.

After talking with my physician and reading this form, I give my consent to the procedure(s) described above.

Signature of patient or
Legal Representative: _____ Date: _____ Time: _____

If Legal Representative, relationship to patient: _____

Witness: _____

Verbal or Telephone Consent: Patient cannot consent because: _____

Name of Legal Representative: _____ Date: _____ Time: _____

Witness: _____ Witness: _____

I have explained the risks, benefits, potential complications, and alternatives of the treatment to the patient and have answered all questions to the patient's satisfaction, and he/she has granted consent to proceed.

Physician signature: _____ Date: _____ Time: _____

S10013E (rev. 6/05)

