

## CONSENT FOR MEDICAL TREATMENT, ANESTHESIA OR OTHER PROCEDURE

Patient name:	Provider:	Room #:	Medical record #
Facility name: <b>Garfield County Hospital District</b>		Patient SS#	Medicare #

Washington State law assures that you have the right to make an informed consent decision prior to any medical procedure. Please complete each section of this form.

I authorize _____ to treat the following condition: _____ _____ _____
The planned procedure is: _____ _____ _____

I acknowledge that during the course of the procedure, unforeseen conditions may necessitate addition procedures other than those originally planned. I authorize my physician to perform such surgical procedures that are necessary.

I have been informed of the significant risks involved in this procedure. I understand that no guarantee as to outcome has been made to me.

I consent to the administration of anesthesia. I understand that anesthetics may involve risks or complications.

**Full disclosure:** I certify that my physician has informed me of the risks and benefits of the medical procedure described on this form. This includes possible significant risks, complications and anticipated results; the alternative forms of treatment, including non-treatment and their significant risks, complications and anticipated results.

**Limited disclosure:** I certify that my physician has offered explain to me the risks and benefits of the medical procedure described on this form. I do not wish to have these risks and facts explained to me. **(initial)** \_\_\_\_\_

### PHYSICIAN'S STATEMENT

The medical procedure stated on this form, including the possible risks and complications have been explained by me to the patient or his/her designated representatives, and approved.

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Physician signature	Date	Time
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### PATIENT OR DESIGNATED REPRESENTATIVE ACKNOWLEDGEMENT

I acknowledge that I have read (or have had read to me) and fully understand the risk and benefits of the procedure explained above.

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Patient or designated representative signature	Date	Time
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### WITNESS ACKNOWLEDGEMENT

I acknowledge that I have witnessed the signature on this document.

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Witness signature	Date	Time
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