☐ **Rhode Island Hospital**
593 Eddy Street, Providence, RI 02903

☐ **The Miriam Hospital**
164 Summit Avenue, Providence, RI 02906

Acknowledgement of Consent for Surgical or Other Procedure

You have the right to be informed about the surgical or other procedure which your physician recommends so that you can make an informed decision whether or not to undergo the procedure. The purpose of this form is to provide written acknowledgment of your consent.

1. I voluntarily authorize Dr. _____ and assistants to perform the surgical or other procedure described below:

   Procedure to be Performed:

   _____

   _____

2. My condition and the above procedure have been described to me. Alternative treatments for my condition and the risks of alternative treatment or no treatment at all have been explained.

I understand that the administration of anesthesia, conscious sedation, medical and surgical procedures involve risks. These risks include allergic reactions, bleeding, blood clots, infections, adverse side effects of drugs, and even loss of bodily function or life. The possible need for blood transfusions was explained where appropriate, along with a discussion of the potential risks, benefits and alternatives to transfusion. I understand that there may be other unforeseen risks or complications of the procedure. I understand that there may be additional surgery or procedures which may be required, and I consent to those which in my physician's professional judgment are necessary.

I understand that this is a teaching facility and that the Hospital may use for teaching, research or scientific purposes, or may otherwise dispose of, tissue, fluids or organs removed during the procedure. I also acknowledge that residents and assistants designated by my physician may participate in the procedure and there may be other observers or vendors present.

I understand that I am under no obligation to proceed with the surgery or procedure until all requested information has been provided and all my questions have been answered to my satisfaction. I acknowledge that this has been done.

_____ _____
PATIENT'S NAME (PRINTED) PATIENT'S SIGNATURE

_____ _____
PATIENT'S AGENT OR REPRESENTATIVE (IF PATIENT UNABLE TO CONSENT) RELATIONSHIP TO PATIENT

DATE SIGNING _____ , 20 TIME _____ A.M./P.M.

Physician's Acknowledgment

The undersigned confirms that informed consent, as described above, has been given by the patient. I have also discussed the possible need for blood transfusions including the potential risks, benefits and alternatives to transfusions and consent was obtained.

_____
PHYSICIAN'S SIGNATURE