PATIENT'S CONSENT FOR SURGICAL MEDICAL AND/OR OTHER TREATMENT

PATIENT: _____ **DATE:**_____

1. I hereby authorize Dr. _____ to treat the illness(es) and/or condition(s), which appear indicated by the diagnostic studies already performed and the clinical judgement and opinion of the physicians.
2. I understand the proposed or contemplated procedure to be:
   _____
   _____
3. My physician has explained to me the general nature of my condition, the proposed treatment, procedure, examination, or test, the expected outcome, the potential risks, and the reasonable alternatives.
4. My physician has explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) or different procedure(s) than those set forth in #2. I, therefore authorize and request that the above named physician, to perform such surgical, medical and/or other procedures as are desirable in the exercise of professional judgement. The authority granted shall extend to remedying all conditions that require treatment and/or were not known at the onset of the procedure including, but not limited to, blood transfusions, removal of tissue and/or administration of medications.
5. My physician has informed me that there are risks including, but not limited to severe loss of blood, infections, DVT, pulmonary embolus, fracture of bone, rupture of ligaments and tendons, nerve injury, vascular injury, loss of motion, persistent pain, limb length discrepancy, possible need for future surgery, risks of anesthesia, stroke, loss of limb, loss of life, and cardiac arrest that are attendant to the performance of any surgical medical and/or other treatment of procedure.
6. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.
7. I also consent to the disposal or retrieval study by authorities of DeClaire LaMacchia Orthopaedic Institute of any severed or amputated member and/or tissue or parts, which it may be necessary to remove during such operation.
8. I hereby voluntarily authorize and consent to the observation of the procedure by third parties as may be necessary for the observer's education or as a consequence of my request or the request of my physician. I hereby release the Surgery Center, Crittenton Hospital Medical Center ("Hospital"), each of their directors, officers and employees and my physician and his or her

   employees from liability for any claim arising out of such observation, including any imaging, photographs, or video performed.
9. In the event my health care provider involved in my care is exposed to my blood or body fluids, I understand that according to Michigan Law, the Surgery Center and/or the Hospital may draw and test my blood for any and all communicable disease, and I hereby consent to such testing. I understand that the results of this blood test will be a part of my medical records and will be treated confidentially. I understand that the Surgery Center and the Hospital are required by Michigan Law to report positive test results and test subject's name to public health authorities.
10. If medical devices or implants are used in this procedure, I understand that the Federal Food and Drug Administration (FDA) requires tracking of certain devices via the model number matched with the patient's social security number. Therefore, I consent to the release of my social security number ***FOR THIS PURPOSE ONLY.***
11. I understand that the physicians providing services to me, including but not limited to, the surgeon, anesthesiologist, radiologist and pathologist are independent contractors with me and are not employees or agents of the Surgery Center or the Hospital. When a patient is under the care and supervision of a physician who is an independent contractor, it is the responsibility of the Surgery Center and its nursing staff to carry out the instructions of such physician. Neither the Surgery Center nor the Hospital is responsible for the medical decisions or actions of such physicians.
12. This form has been fully explained to me and I certify that I understand its contents.

_____ _____
Signature of Patient/Parent/Legal Guardian Witness

_____ _____
Date Time

If not signed by the patient, please indicate which situation applies below:

☐ Patient is a minor (under 18) □ Other: _____