

2500 Grant Road, Mountain View, CA 94040-4378 815 Pollard Road, Los Gatos, CA 95032

fellows, residents, medical students, surgical assistants and approved health care practitioners may observe care, and if appropriately trained, participate in aspects of the operation or procedure. These practitioners will be under the supervision of the attending doctor. Furthermore, if the procedure involves specialized equipment or medical device(s), the manufacturer's representative(s) may be present during the procedure to assist in the selection or calibration of the equipment or device(s) and in the related treatment.

- 8. I authorize the hospital to use and/or dispose, at its discretion, of any blood, bodily fluid, tissue, body part or medical device removed or obtained during my procedure for research that may be conducted by El Camino Hospital or unaffiliated academic or commercial third parties if allowed under legal requirements and relevant policies.
- 9. I authorize the photographing or videotaping of this procedure to assist in treatment, quality assurance and for internal or external activities consistent with the Hospital's mission such as education and research conducted in accordance with Hospital policies. I understand I may waive this right any time before the procedure and I will inform my physician regarding this decision. □ No, I do not authorize the taking of any pictures of videos and have informed my physician of this decision.
- 10. I understand that the physician may order the use of blood transfusions and/or blood products in connection with the operation or procedure and throughout this hospitalization, and acknowledge that the doctor has explained the risks, benefits and alternatives to transfusion and/or use of blood products. I understand that the risks associated with transfusion and/or use of blood products include reactions, transmission of disease, and unforeseeable risks including death. I consent to the use of blood and/or blood products during the operation or procedure and subsequent hospitalization if indicated. If applicable, I have received a copy of the brochure, A Patient's Guide to Blood Transfusion.

■ No, I do not consent to the use of blood or blood products. I	understand I must notify
my physician immediately and will discuss with physician and	sign the: Patient
Preference Acknowledgement for Blood Management form.	(Please initial)

Patient / Legal Representative Signature	Date	Time		
Relationship to Patient	Phone Con	Phone Contact During Procedure		
Witness Signature	Date	Time		
Witness #2 Telephone Consent If this document was translated/interpreted:	Date	Time		
or designation of the second o	าวได้ส สาม เม	may exessing to a		
SIGNATURE of Translator LANGUA	GE LINE ID	Date Time		
Language				





2500 Grant Road, Mountain View, CA 94040-4378 815 Pollard Road, Los Gatos, CA 95032

Patient La	abel	

Informed Consent for Surgical/Medical Procedures

the risks, anticipated benefits and alternatives pertinent questions were answered and the patient consents to the street of the patient consents to the patient consents t	to this operatio	tment noted below, n /procedure/treatm	including ent. All
Print Physician Name:	101 106	in the 10 stituin	
Physician Signature:	Date:	Time:	onu bout
Procedure Name: (Physician to complete or enter order for nurs	ing to complete sec	tion with name of exact p	procedure)
I give permission to:hospital staff, to perform the following procedure(s):	, associates	s, assistants and/or	assigned
with the third the second seco		in a line i unatana	

Patient Information: I acknowledge that I have read and understand the information provided on this form and have had the opportunity to ask questions. By my signature below, I confirm that:

- I understand that the physicians caring for me are not agents or employees of the hospital, but are independent contractors of the hospital. The hospital maintains personnel and facilities to assist doctors in the performance of surgery/procedure.
- 2. I understand I have the right to be informed of any independent medical research or significant economic interests my physician may have related to the performance of the proposed operation or procedure.
- 3. I have been provided an explanation of the nature of the operation/procedure, the anticipated benefits, likelihood of treatment achieving my goals, the risks, side effects, and potential problems related to recuperation. The alternatives, the risks and benefits of these alternatives and the risks of having no treatment have also been explained to me.
- 4. I understand that in an emergency there may be different or further procedures required if the doctor believes they are necessary, and I consent to such procedures.
- 5. I understand that any operation or procedure may involve the risk of an unsuccessful result or complication, including but not limited to bleeding, infection, nerve/nervous system damage, injury to organs/structures or even death from both known and unforeseen causes. I understand that good results are expected, however there is no guarantee as to the result of the procedure.
- 6. I understand that the administration of anesthesia and/or sedation and associated procedures may be necessary to assure safety and comfort during the procedure. I understand that there are risks associated with the use of anesthesia and/or sedation, and that the appropriate practitioner will discuss these risks with me prior to the procedure.
- 7. In addition to caring for patients, El Camino Hospital participates in offering education to healthcare providers. As part of the medical education and training program, postgraduate

