

PATIENT: _____ Patient No.: _____

Washington State law guarantees that you both have the *right and obligation* to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. I hereby authorize Dr. _____ and/or such associates, assistants or designees, including medical residents in training as may be selected by said physician to treat the following condition(s) which has (have) been explained to me: *(Explain the nature of the condition(s) in professional and lay language.)*

2. The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand them to be: *(Describe procedure to be performed in professional and lay language.)*

At: Swedish Medical Center _____

3. I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those above set forth. I therefore authorize my above named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her or their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

4. I have been informed by my physician that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

PHYSICIAN'S STATEMENT: The medical procedure or surgery stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results, was explained by me to the patient or his/her representatives before the patient or his/her representatives consented.

PHYSICIAN'S SIGNATURE _____ DATE _____ TIME _____

PATIENT OR PATIENT REPRESENTATIVE'S ACKNOWLEDGMENT: I acknowledge that I have read (or have had read to me) and fully understand the above consent, the explanations referred to were made and all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE _____ DATE _____ TIME _____

WITNESS ACKNOWLEDGMENT: I acknowledge that I, as witness, have identified the above individual and have observed his/her signature on this document.

WITNESS SIGNATURE _____ DATE _____ TIME _____

NAME PLATE



SWEDISH MEDICAL CENTER
747 BROADWAY, SEATTLE, WA

STOCK #21 (08/02)