Children's HOSPITAL • ST. LOUIS BJC HealthCare

Washington University in St. Louis Physicians

CONSENT FOR SURGERY OR DIAGNOSTIC PROCEDURE

By Physicians on the Staff of St. Louis Children's Hospital or Barnes-Jewish Hospital

1. I authorize performance upon ☐ Myself ☐ Patient (as shown above) of the following operation or procedure:

   _____

   _____

   _____

   _____

   by_____and such persons from the staffs of either hospital who may be present.

2. This procedure will be performed at St. Louis Children's Hospital unless otherwise specified:
   ☐ Children's Specialty Care Center ☐ Barnes Jewish Hospital ☐ Center for Advanced Medicine
   ☐ Other:_____

3. I also consent to the performance of such other unforeseen operations or procedures as are indicated.

4. The nature and purpose of the operation or diagnostic procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications despite precautions have been explained to me. I understand that all procedures are associated with certain risks and acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

5. I understand there may be other healthcare providers who may perform parts of the procedure, including anesthesia providers, residents, physician assistants, nurse practitioners and others. All persons during the procedure will act within their own abilities, privileges, according to hospital policies and under my physician's supervision.

6. I understand my physician will be present for all key or critical parts of my procedure, though not necessarily for the entire time I am in the procedure room.

7. I consent to the administration of such anesthetic procedures as may be considered reasonable and understand that certain risks attend all anesthetics. I also consent to the administration of blood, drugs, medicines and other substances reasonably considered advisable and the use of x-ray and other procedures and devices which my physician considers to be reasonably useful.

8. For the purpose of advancing medical education, I also consent to the admittance of observers to the operating and procedure rooms, and to the taking of any photographs in the course of the operation or procedure.

9. My physician or the hospital staff may examine, use (including use in other patients) or dispose of any bones, organs, tissues, fluids or parts removed from my body.

We/I certify that we/I have read and understand the above consent to operation or diagnostic procedure, that the explanations therein referred to were made and to my satisfaction, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before we/I signed. I agree my physician has given me the right to ask questions and I have read this whole form. I understand this form is valid for 60 days from the date of the signature.

Signed:_____ Date:_____Time:_____
(Patient or Representative)

Physician responsible for this procedure (Print Name):_____

The patient's diagnosis, the purpose, benefits, material risks, and alternatives of the recommended procedure were discussed. The patient or their representative understood the discussions and consented to the procedure.

Signature of Attending/Proceduralist:_____Date:_____Time:_____

skin punch biopsy