

GUAM MEMORIAL HOSPITAL AUTHORITY
Informed Consent for Surgery, Procedures and Transfusion

I, _____, authorize the following Surgeries, Procedure(s) or Transfusion(s) **(No Abbreviations)**

to be performed by Dr. (s)

I understand that a representative from a medical company may be present during the surgical procedure to provide verbal technical advice to the surgeon, anesthesiologist, and/or operating room staff.

Consent to additional Surgeries/Procedures. During the course of the operation(s)/ procedure(s), unforeseen conditions may arise requiring additional surgeries or procedures to promote my well-being. I **consent** to other surgeries/procedures as may be considered necessary or advisable by my providers under the circumstances.

Consent to administration of blood and blood products. I understand that I may need blood or blood products before or during my surgery or special procedure. I may also need it during the period of time after surgery. I understand that there are risks to receiving blood and blood products, including immune/allergic reactions and some severe infections. I consent to receive blood or blood products as believed needed by my provider.

Discussion of Risks/Benefits/Alternatives. My provider has explained the following to me:

- The nature, purpose, and possible consequences of the surgery/procedure/blood transfusion as well as benefits, likelihood of achieving therapeutic goals, the significant risks involved, and possible complications.
- The expected post-operative function level and expected alterations in lifestyle/health status.
- The risks and benefits of treatment alternatives.
- The risks and benefits associated with not receiving care or performing the surgery/procedure.

I understand that the explanation I have received is not exhaustive and that there may be other, more remote risks and consequences. I have been advised that a more detailed explanation will be given to me if I desire. I have received no guarantee or warranty concerning the results, outcome, or cure and have been given an opportunity to ask, and have answered, questions to my satisfaction.

Dental Waiver. I have been advised that dental prosthetic devices including, but not limited to dentures, bridges, caps, crowns, fillings, dental implants, etc., are more easily damaged than normal teeth. I have been advised to remove all removable prosthetic devices prior to surgery and I agree that responsibility for loss or damage will be mine if I fail to remove such dental or other prosthetic devices. I understand that loose or damaged teeth are more prone to additional damage during the operation/procedure and agree that responsibility for further damage to loose/damaged teeth will be mine alone.

Consent to Imaging. For the purpose of diagnosis and treatment, I consent to photography and videography of the operation/procedures revealing portions of my body, with the understanding that my identity will not be revealed. I understand that I may revoke this consent to imaging or the publication/dissemination of images captured at any time.

Social Security Number. In the event a device is implanted during my operation(s)/procedure(s) and federal law requires tracking of the device, I consent to the release of my social security number for tracking purposes.

(CONTINUED ON OPPOSITE SIDE)

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GMHA FORM# 0045 STOCK# 990045

FORM REVISED: 09/2025

APPROVED DATE: **Surgery Dep.** 03/2025, **Anesthesia Dept.** 04/2025, **MEC** 08/2025, **HIMC** 09/2025

PATIENT ID LABEL

If a practitioner other than the operating practitioner, including but not limited to, other physicians, residents, advanced practice providers, and medical and other applicable students will be performing important tasks related to the surgery, or examinations or invasive procedures for educational purposes including, but not limited to, breast, pelvic, prostate, and rectal examinations, I consent to their presence and they are listed here:
(PRINT) _____

_____.

Surgeon Attestation to DNR/DNI Conversation with Patient. In accordance with the American College of Surgeons (ACS), I, as the Surgeon, attest that I have had a conversation with the patient or their legal representative informing them of their right to either: suspend DNR/DNI orders or retain DNR/DNI orders during surgery and the perioperative period.

(INITIAL OF SURGEON ATTESTING THE ABOVE) _____

I **CONSENT** to the Above Detailed Surgery, Procedure or Transfusion

Patient or Legally Authorized
Representative's Signature

Relationship to Patient

Date & Time

Provider's Signature

Date & Time

In the event consent of the patient or their legal representative is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person effected or could reasonably result in disfigurement or impair faculties, the signature of a second Provider is required.

2nd Provider's Signature

Date & Time

In the event the patient's legal representative is not readily available during a non-emergent procedure for signature when the patient is not able to consent for themselves, verbal consent via telephone is acceptable. A witness signature to that verbal consent is required.

Witness's Signature (PRINT & SIGN)

Date & Time

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