CONSENT TO OPERATION

1. I authorize Dr. Amacher _____, and any other practitioners or persons as are needed to assist him/her, to treat or diagnose the following condition(s): __ *Dental Caries* _____ _____ and I authorize my doctor to utilize Analgesia/sedation/ topical/ local anesthesia as deemed necessary.
2. The doctor recommends the following operation/procedure as treatment of my condition: _____ *Dental treatment under general anesthesia* _____
3. The doctor has explained the procedure(s) to me and I understand the nature and the purpose of the procedure to be: *The treatment/rehabilitation of dental caries*
4. My doctor has explained the risks and consequences that are associated with the procedure(s) described above. I understand that all surgery involves risks and consequences such as failure of the procedure to achieve the desired result, loss of blood, infection, and/or heart stoppage. Some of the other risks my doctor discussed with me are: _____
5. I permit the doctor named above and such other practitioners or persons as are needed to perform the procedure(s) described above. The doctor has informed me that the following practitioners: ____ Resident, ____ Physician's Assistant, _____ Other will be performing the following significant surgical tasks: _____

   Significant surgical tasks that may be performed during the operation include, but are not limited to opening and closing, harvesting grafts, dissecting tissues, removing tissue, implanting devices and altering tissues.
6. I am aware that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees or representations have been made to me as to the results of the operation or procedure(s).
7. My doctor has explained to me that during the procedure, unforeseen conditions may be revealed that require additional surgery including extension of the original procedure(s) or different procedure(s) than those described above. I authorize my doctor or his designees, to perform such additional surgery as they may deem medically necessary and desirable, and if delay in the performance of such procedures might impair my health.
8. The risks and benefits of blood transfusion and available alternatives have been explained and I authorize their administration if deemed medically necessary and desirable.
9. My doctor has explained to me that there may be alternative methods of treatment for my condition which include the following: __ *No Treatment* _____

   My doctor has explained the risks and benefits of these alternative treatments, and the risks and benefits of not undertaking treatment.
10. I consent to the presence of medical students, residents, and other health care providers or student health care providers and observers in the operating room in accordance with the usual practices of the facility. I also agree that still pictures and video tapes may be made for diagnostic or educational purposes unless I agree otherwise.
11. I understand and agree that any tissues or parts removed from me may be tested for infectious diseases, retained, preserved, photographed, and used for scientific or teaching purposes, or may be disposed of by the Hospital in accordance with its usual practice.
12. For Patients with DNR Orders: I understand my treating physician or anesthesiologist or other qualified practitioner will discuss with me the risks and benefits of continuing a DNR order during this procedure.
13. I have read this Consent and understand it. I have received all the information I desire concerning the procedure(s), and all of my questions have been answered to my satisfaction.

Signature of Physician	*Date/Time*	*Signature of Patient*	*Date/Time*
Witness	*Date/Time*	*Signature of Legally Authorized Representative*	*Date/Time*
Reason Patient unable to consent		*Relationship to Patient (If Patient unable to consent)*	

IT IS YOUR RIGHT TO DETERMINE THE EXTENT OF YOUR MEDICAL SURGICAL CARE. IF YOU HAVE ANY FURTHER QUESTIONS, ASK YOUR PHYSICIAN BEFORE SIGNING THIS FORM.

CARILION CLINIC
Post Office Box 13727
Roanoke, Virginia 24036-3727

PATIENT IDENTIFICATION