Mercy

Consent to Surgical, Diagnostic, or Therapeutic Procedure and Anesthesia

I have had sufficient opportunity to discuss my condition and treatment with my credentialed health care providers and his/her associates, and all of my questions have been answered to my satisfaction. I have read and understand this consent and all blanks were filled in. If I believe any part of this consent does not apply to me, or if I do not consent to them, I have drawn a line through the paragraph or sentence. I believe I have adequate knowledge upon which to base an informed consent to the proposed treatment.

I, [redacted], give my consent and authorize Dr(s). [redacted] with associate(s) or assistant(s) of his/her choice and the staff of Mercy Hospital to perform the following procedure(s) on me, or on [redacted], the patient for whom I am authorized to consent:

CORONARY ANGIOGRAPHY

Patient is unable to sign or consent because patient is ___ years of age, or patient is unable to sign because:

[redacted]
Patient's Signature or Signature of Person Authorized To Consent for Patient

Date: [redacted] **Time:** [redacted]

Relationship to Patient

Witness: [redacted]

Date: [redacted] **Time:** [redacted]

I certify that I personally explained the operation(s)/procedure(s), treatment goals, reasonable alternative methods of treatment, the risks involved, the possible consequences, and the possibility of complications to the patient or if the patient is unable to consent, to the person authorized to consent for patient.

[redacted]
Credentialed Health Care Provider Signature
(Physician, Advanced Practice RN, Physician Assistant, Dentist, Psychologist, Podiatrist, Chiropractor)

Date: [redacted] **Time:** [redacted]

Credentialed Health Care Provider Signature
(Physician, Advanced Practice RN, Physician Assistant, Dentist, Psychologist, Podiatrist, Chiropractor)

Date: _____ **Time:** _____

PATIENT IDENTIFICATION