1. I, [redacted] (, or [ ] as ☐ Parent ☐ Representative ☐ Guardian (Check One) acting on his/her behalf,) request the procedure/operation/treatment set out below.

2. I have requested Dr(s). JOSHI MD, ARJUN perform and supervise my procedure/operation/treatment which has been explained to me to be:

RIGHT PAROTIDECTOMY, CONDYLECTOMY, TMJ RECONSTRUCTION WITH RIB CARTILAGE, PEDICLED TEMPORALROPARIETAL FLAP

My doctor's explanation informed me about my medical condition as well as the common foreseeable benefits and risks of the procedure/operation/treatment as well as of its reasonable alternatives, if any.

3. I know, too, that during my procedure/operation/treatment it may become apparent to my doctor that in his/her professional judgement further procedures, operations, or treatments may be necessary. I therefore authorize modification or extension of this consent to include those additional procedures which in my doctor's professional judgement are medically necessary under these special circumstances and for my benefit with the exception of (check one): ☐ type of procedure _____ ☐ no exceptions

4. I understand that if a member of the Department of Anesthesiology is to participate in my care, for general, regional, or monitored anesthesia care, a separate consent will be obtained for these services.

5. If my doctor has indicated to me that I will require a local anesthetic as part of my procedure/operation/treatment, I authorize its administration. I acknowledge that my doctor has explained the benefits and risks of my receiving a local anesthetic as well as a reasonable alternative, if any. Potential risks may include but are not limited to pain at the injection site, or very rarely allergic reaction to the anesthetic. Further, I understand that during my procedure/operation/treatment, unforeseen circumstances may require alternative methods of anesthesia, such as general, and I therefore authorize modification of anesthesia administration which my doctor's professional judgement indicates to be necessary under the circumstances.

6. If it is anticipated that I may require transfusion of blood or blood products during my procedure, I will be required to sign a separate INFORMED CONSENT TO BLOOD TRANSFUSION AND/OR BLOOD COMPONENT ADMINISTRATION form. If in the event of an unanticipated emergency during my operative care and based on the medical judgement of my physician, I require the transfusion of blood or blood products, I understand they will be administered and agree to such action being taken.

7. Knowing that the George Washington University Hospital is a teaching institution, I understand that along with my doctor and his/her assistants and designees, other Hospital personnel such as residents, trainees, nurses, and technicians will be involved in my procedure/operation/ treatment and care. I understand and agree to the presence of appropriate observers for the advancement of medical education and care.

8. I consent to the appropriate disposal of any tissue or part removed from my body and to the taking of photographs during the procedure/operation/treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

9. I agree to the appropriate disposal of any tissue or part removed from my body, to the taking of photographs during the procedure/operation/ treatment for research, teaching, or scientific purposes as long as my identity is not disclosed, and to participate in the _____ research protocol/program.

**PATIENT AFFIRMATION**

By signing this request form, I am indicating that I understand the contents of this document and agree to its provisions. I know that if I have concerns or would like more detailed information, I can ask more questions and get more information from my attending physician. I am also acknowledging that I know that the practice of anesthesiology, medicine and surgery is not an exact science and that no one has given me any promises or guarantees about the designated procedure/operation/treatment or its results. I fully understand what I am now signing of my own free will.

| WITNESS TO AFFIRMATION AND SIGNATURE | DATE TIME | PATIENT SIGNATURE (or Parent, Guardian or Representative) | DATE/TIME |
|---|---|---|---|
| | 7-21-14 | | |

**Signature of physician obtaining consent if other than physician performing procedure** _____ **Date** _____ **Time** _____

**PHYSICIAN ATTESTATION**

I attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the procedure as well as its reasonable alternative(s), if any. Further questions with regard to this procedure have been answered to his/her apparent satisfaction.

| PHYSICIAN'S NAME - PRINTED | PHYSICIAN SIGNATURE | DATE/TIME |
|---|---|---|
| JOSHI | | 7/21/14 |

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

UHS

Patient Label