



UW Health uwhealth.org
(University of Wisconsin Hospitals and Clinics Authority)

**CONSENT TO OPERATIONS, ANESTHETICS,
DIAGNOSTIC RADIOLOGY, TRANSFUSION,
OR OTHER PROCEDURES**

Index to Consent-Treatment/Procedures

Date:

I request and authorize Dr. O'Neill and/or other doctors, assistants, students, and staff who may be assigned to my care, to perform on:

's Name or "Myself")

the following operation(s) or procedure(s): Blood transfusion

When the procedure is planned for one side of the body, indicate the planned side here: ☐ RIGHT ☐ LEFT

I have read the **reverse side of this form** and have crossed out, limited, or made the following changes: _____

A copy of the front side of this form will be used as authorization for **blood products and other services** described on the back of the form unless indicated above.

By signing below, I acknowledge (1) that I have read **BOTH SIDES OF THIS FORM**, (2) that I understand the form and information provided by my doctor or doctor's designee, (3) that I have had the opportunity to ask questions and have had them answered to my satisfaction, and (4) that I hereby give my authorization and consent to the performance of the operation(s) or procedure(s) listed above. The risks, and benefits of, and viable alternatives to the operation(s) or procedures(s) have been explained to me and I agree to proceed.

AUTHORIZING SIGNATURES:

Signature of Patient/Representative _____ Date: _____ Time: _____ AM
PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name:
Patient is: _____
Legal Auth:
☐ Health Care Agent ☐ Other _____

Physician Signature: _____
Date: Time: 7:00

Interpreter or Reader Signature (if applicable) _____

Print Interpreter or Reader Name _____

Date _____ Time _____ AM
PM

* Only required if patient signature not obtained by physician or when telephone consent obtained.