

GBMC HEALTHCARE  
6701 North Charles Street  
Baltimore, Maryland 21204

**CONSENT TO DIAGNOSTIC, OPERATIVE  
THERAPEUTIC, BLOOD TRANSFUSION AND  
PHARMACOLOGICAL PROCEDURE**

Date of admission: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_ AM  
PM

Name of Patient: \_\_\_\_\_(type or print.)

1. I consent to the performance of the following procedures upon the Patient, under the direction of Dr. JOHN YACOB, as the physician in charge; these procedures may be performed by him/her or anyone whom he/she may designate:

(a) Physical examinations, other routine diagnostic procedures and routine medical treatment;

(b) The following operative, special diagnostic or therapeutic procedures:

\_\_\_\_\_

\_\_\_\_\_

(c) The injection or other administration of the drugs or other substances incidental to any procedure described in subparagraph (a) above.

\_\_\_\_\_

(d) Any other procedure related or incidental to those enumerated above, if within a reasonable degree of medical certainty the procedure is necessary to avoid a substantial risk of death or immediate and serious harm to my health, and someone authorized to give consent on my behalf is not reasonably available to make the decision.

(e) At the option of my surgeon, the videotaping or photographing of any surgical procedure for diagnostic purposes or for educational or research use under circumstances in which my identity will be protected from disclosure to persons not otherwise involved in my care.

2. These procedures, possible alternative procedures, and their respective risks have been explained to my satisfaction by the physician in charge, including but not limited to the risks and alternative listed in Section 6.

**NOTE: THIS IS A TWO SIDED FORM.**



\* CONSENT \*

3. I consent to the administration of blood and blood products, if required, by any person qualified to do so. I understand that blood or blood products may be needed to correct anemia, replace blood lost during a procedure or to help my blood clot. Uncommon reactions may include chills, fever or a rash. Rare but more serious conditions may be heart, kidney or other organ failure, a reaction due to blood incompatibility or acquiring an infectious disease such as Hepatitis or HIV (AIDS.) These procedures, possible alternatives such as autologous donations, and their respective risks and benefits have been explained to my satisfaction.
4. I consent to the study, use and disposal by Medical Center authorities of any tissue or parts that may be removed.
5. No warranty or guarantee has been given to me by anyone as to (a) the results that may be obtained from the procedures covered by Paragraph 1, or (b) the fitness or quality of any drug, anesthetic, blood or blood product or other substance to be used in those procedures.
6. Special remarks (List risks and alternatives to procedures):

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**DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE WITH WHAT IT SAYS**

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**WITNESS SIGNATURE**

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(Print Name)

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(Address)

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(Patient Signature)                      (Date)

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(Other Authorized or Required to Consent)

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(Print Name)

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(Relationship to Patient)

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(Address)

**NOTE: THIS IS A TWO SIDED FORM.**