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1. I hereby authorize Dr. __________________ to perform (describe procedure in professional and lay terms): NEONATAL CIRCUMCISION, REMOVAL OF FORESKIN FROM THE PENIS ___________________________ ___________________________ ___________________________ ___________________________ upon me. I understand that the procedure is to be performed at EvergreenHealth. This has been recommended to me by my physician in order to diagnose and/or treat the following diagnosis or condition: UNCIRCUMCISED FORESKIN ___________________________ ___________________________ ___________________________ ___________________________

2. Other credentialed practitioners may assist with the procedure(s) as necessary. These practitioner(s) is scheduled to assist and may perform the following surgical tasks: opening and/or closing, altering tissues, inserting medical device(s), dissecting (cutting) tissue, organ or bone: (if applicable). Name: NONE ___________________________ ___________________________ ___________________________ ___________________________

3. I recognize that, during the course of the operation, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore authorize my above-named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

4. My provider has fully explained to me:
   a. The nature of the condition being treated.
   b. The nature & effect of the treatment(s) or procedure(s) to be performed.
   c. The known material risks and complications of the treatment(s) or procedure(s).
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   e. Other kinds of treatment.
   f. The expected risks, benefits and results from other kinds of treatment and no treatment at all.

   I have been given an opportunity to ask questions and all of my questions have been answered fully and satisfactorily.

5. I have been informed that there are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I have received no warranty or guarantee from anyone as to the results or cure.

6. I consent to the administration of blood and blood products if deemed medically necessary. I understand that all blood and blood products involve risk of allergic reaction, fever, hives, and in rare circumstances infectious diseases such as hepatitis and HIV/AIDS. I understand that precautions are taken by the blood bank in screening donors and in matching blood for transfusion to minimize those risks. (Consent for Blood Transfusion form must be completed unless emergent).

If the patient declines, cross out section 6 and both patient and physician initial.
7. **Sedation/Anesthesia:**
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I **Certify That This Form Has Been Fully Explained To Me, That I Have Read It Or Have Had It Read To Me, That The Blank Spaces Have Been Filled In, And That I Understand Its Contents.**

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Relationship of Authorized Representative to Patient: ______ Parent/Guardian __________________

*Patient cannot consent or authorize because ____________ Newborn ______________________

☐ Telephone Consent  ☐ Interpreter Used

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**EvergreenHealth**
Kirkland, WA 98034

**INFORMED CONSENT**
FORM ID ADM 169 - CIRC
Approved 02/16
Page 2 of 2

Patient Name: ________________________________
Birthdate: ________________________________

*(Place Patient Identification label in this box.)*

Original - Medical Record  Copies to Patient and Physician

MR
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