SCENIC VIEW
Outpatient Surgery Center
A DIVISION OF GCRMC

2351 Twenty-Fifth Street
Complex B
Alamogordo, New Mexico 88310

REQUEST FOR SPECIALIZED TREATMENT OR PROCEDURE

PATIENT STAMP

Hospital No. _____ Attending Doctor _____

Name of Patient _____ Age _____

Date Signing _____ Time _____ a.m. p.m.

1. I request and authorize Dr. _____ and his colleagues with the exception of

   _____ to provide the patient _____

   using the facilities and personnel of the hospital, the following procedure: _____

   _____

2. The nature and purpose of the above named treatment or procedure and the possibility of complications have been explained to me. No guarantee has been made to the results that may be obtained.

3. If unforeseen conditions arise in the course of the procedure calling, in the doctor's judgement, for procedures in addition to or different from those not contemplated, I request and authorize the doctor to do whatever he deems necessary and advisable.

4. I request and authorize the administration and use of such anesthetics and performance of such services involving pathology and radiology as the doctor and his colleagues may deem necessary and advisable with the exception of (none or a particular one). _____

5. I understand those persons administering anesthesia or performing services involving pathology, radiology and special duty nurses employed by me are not necessarily employees of the hospital.

6. The hospital may retain, preserve and use for scientific or teaching purposes or dispose of at its convenience and in accordance with the accustomed practice the specimens, tissues, parts or organs taken from the patients body during the patient's hospitalization and / or as a result of the procedure performed upon the patient.

7. For the purposes of Medical Device Tracking, I agree to the use of my Soc. Sec. Number for identification.

I CERTIFY: This form has been explained to me; I have read the contents of this form or the contents have been read to me; I understand its contents; the explanation of the contents was made; all blanks or statements requiring insertion or completion were filled in. All terms not applicable were stricken before I signed.

_____ _____

Witness Patient

_____

Witness

Patient cannot consent or authorize because _____

_____

_____

_____ _____

Witness Patient Representative

_____ _____

Witness Relationship to Patient