Sutter Health
Palo Alto Medical Foundation

# PART I:
# General Conditions of Admission

Each patient in the hospital is admitted under the care of his or her attending physician. Physicians of the medical staff are not employees of the hospital and Menlo Park Surgical Hospital (MPSH) is not responsible for the actions of physicians. The undersigned understands that he/she may require the service of physicians or groups of physicians who are not hospital employees that could include pulmonologist(s), internist(s), anesthesiologist(s), cardiologist(s), radiologist(s), emergency room physician(s) or other professional(s) or supplier(s) of service. MPSH does not assume the liability for the activities of such professionals or suppliers of service.

**A. MEDICAL AND SURGICAL CONSENT:** The undersigned consents to any examination (X-ray or otherwise) including but not limited to laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedure or treatment (including placement of prosthesis within a patient's body), radiation therapy (X-ray, cobalt, radium or other), photograph and/or other services rendered the patient by members of the medical staff, their representatives and/or associates, and hospital employees under the instructions of the physician or dentist. The undersigned also consents to observation of surgical, diagnostic or other procedures by medical personnel in training or by other appropriate persons permitted by the attending physician or dentist and allowed by hospital or departmental policy.

**B. GENERAL-DUTY NURSES:** This hospital provides only general-duty nursing care unless, upon orders of your physician, you require more intensive nursing care. If your condition requires the service of a special-duty nurse, it is agreed that such must be arranged by you or your legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that you are not provided with such additional care.

**C. TISSUE DISPOSAL:** Should your hospital stay involve the removal of any tissue or parts of your body, including fetus or afterbirth, they may be retained or disposed of by the hospital.

**D. PERSONAL VALUABLES:** It is understood that the hospital maintains a safe for money and valuables, and that the hospital will not be responsible for loss or damage to any money or property of the patient or others unless delivered to or deposited with the hospital for safekeeping and a written safekeeping receipt issued by the hospital therefor.

**E. SAFETY:** For reasons of safety, personal electrical items will not be used in electrically susceptible areas and cellular phones are prohibited in all areas of the hospital. Personal televisions are prohibited. Only transistor type, battery operated radios are allowed. Any electrical appliances brought in by the patient must be approved by the manager of plant/facility operations.

**F. MEDICAL INFORMATION RECEIVED:** The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he or she has been informed concerning the need for hospital services, the purpose of the patient entering the hospital, planned examinations, procedures and treatments. It is understood that the practice of medicine is not an exact science and no guarantee can be given by anyone as to the results that will be attained.

**G.** The above conditions apply to all units within the hospital system, and this form is valid in each hospital for the length of the admission.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ THE FOREGOING, HAS RECEIVED A COPY HEREOF, IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT AND THE FOREGOING CONDITIONS OF ADMISSION ARE ACCEPTED.

Patient _____ Date _____ Witness _____ Date _____

If patient is a minor or unable to execute above form (because of some disability, including being non composmentis or unconscious, that inhibits or precludes the patient's ability to legally sign), explain the patient's disability below:

_____

Patient's Legal Representative _____ Date _____ Witness _____ Date _____

**Menlo Park Surgical Hospital**
**570 Willow Road, Menlo Park, CA 94025 • (650) 324-8500**