

Cleburne Surgical Center

CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS AND RENDERING OF OTHER MEDICAL SERVICE, INCLUDING CONSENT FOR RELEASE OF RECORDS AND ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS

I, _____ hereby authorize and direct _____, M.D./D.O. and/associates or assistants of his choice to perform the scheduled procedure and any other procedures as he may deem necessary or advisable, on me, my child or ward.

1. The basic procedures of my surgery and the advantages, risks and possible complications of alternative treatments have been explained to me by the doctor. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. As with ALL types of surgery, there is the possibility of complications due to anesthesia, drugs, reactions or other factors which may involve other parts of my body, including a possibility of brain damage or even death. Since it is impossible to state every complication that may occur as a result of surgery, the list of complications in this form is incomplete.
2. I hereby authorize and direct the above named surgeon to arrange for such additional services for me, as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology, and I hereby consent thereto.
3. I authorize the surgery center to preserve and examine for scientific, pathological or educational purposes or to otherwise dispose of the tissue/organs removed during the operation or procedure described.
4. I authorize the administration of transfusions of whole blood products as may be deemed advisable in the judgment of the anesthesiologist, patient's attending physician, and/or his associates or assistants. I understand that blood transfusions are not always success in producing a desirable result. I understand that despite the exercise of due care in the transfusion of blood or blood products is always attended with a possibility of some ill effects. I understand that emergencies do on occasion arise when it may be necessary for the patient's well-being to use existing stocks of blood which may not include the most compatible blood types.
5. I hereby consent to the use of video taping or photography of my surgery at my surgeon's discretion and release Cleburne Surgical Center from all liability from claims of any kind for the taking and use of these photographs or tapes.
6. I am aware that my physician may have an ownership interest in Cleburne Surgical Center. If I choose to go to another health care facility for this procedure, it will have no effect upon my relationship with my physician.
7. I release Cleburne Surgical Center from **ANY** responsibility for loss and/or damage to money, jewelry or other valuables brought into the surgery center.
8. I understand that I have the right to make choices regarding life-sustaining treatment (including resuscitative measures). If I desire to exercise this right, I understand that I must inform my physician of my wishes. I understand that if I have a Living Will, Durable Power-of-Attorney or an Advanced Directive, I must inform Cleburne Surgical Center and present a copy.

Patient Label

9. I understand that in the rare event that hospitalization is required, my physician will arrange for my transfer to a local hospital. I authorize, Cleburne Surgical Center, to send a copy of those portions of my medical record which are available and relevant to the transfer and my continued care, including records related to my condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, and results of any tests. I further authorize the admitting facility, upon my discharge, to release a copy of my Discharge Summary and/or any other relevant information related to treatment received after transfer to the Cleburne Surgical Center.

10. In the event of an incidental exposure of my blood or body fluids to any employee of the Surgery Center, I consent to testing for HIV and Hepatitis.

11. I understand that if may be necessary to be placed under anesthesia in order to perform the above described operation and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesiologist, surgeon and nurse anesthetist. Anesthesia involves risks in addition to the risks of the surgical procedure itself. These risks may include, but are not limited to, adverse drug reactions, brain damage, death, nerve injury, damage to teeth or dental work, damage to vocal cords, respiratory problems, minor pain and discomfort, damage to arteries or veins, headaches, backaches, or worsening of pre-existing disease(s). The purpose, necessity, and risk of anesthesia have been explained to my satisfaction, and there has been opportunity to discuss the proposed treatment and associated risk.

12. I agree to the release of my name, phone number, demographic and pre-surgery status information to the appropriate organization for the purpose of patient outcome studies.

13. I understand that from time to time surgeons bring visitors in the Operating Room. These visitors are medical professionals, but do not participate in any way in the operation. I understand and consent to their presence, but not to their participating in the surgery.

14. I understand that the Cleburne Surgical Center is a facility that promotes educational opportunities for physician assistants and nursing students and therefore, I understand that I may be seen, examined and receive care by supervised participants as part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time. _____ (Pt. Initials)

I AM STATING THAT I HAVE READ THIS CONSENT (OR IT HAS BEEN READ TO ME) AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS.

Time: _____ Patient/Person with Authority to consent for Patient Signature: _____

Date: _____ Witness to signature _____