CONSENT FOR SURGERY

Patient Name: _____ **Physician Name:** _____

Procedure(s): _____

I understand that in order for me to make an informed decision about undergoing surgery or other invasive medical procedures, I should have certain information about the proposed surgery or procedure. My physician has explained the nature and purpose of the operation/procedure to me, potential problems related to recuperation, the risks inherent in the operation/procedure, expected benefits, the likelihood of success, possible results of non- treatment and the possible alternative methods of treatment. My physician has given me the opportunity to ask questions. My understanding of this procedure and complications:_____

_____

I fully understand that all surgical and invasive procedures and anesthesia involve risks of complications, including but not limited to **allergic reactions; significant bleeding; pneumonia; blindness; embolism (air bubble in blood vessel); hematoma (collection of blood in tissue or organs); damage to blood vessels, nerves, and internal organs; disfiguring scar; kidney failure; loss or loss of function of any organ; failure of implanted devices, including vascular grafts; respiratory arrest (inability to breathe);cardiac arrest (heart attack); brain damage; loss or loss of function or sensation of any limb; life threatening infection; wound infection which may require debridement; failure to heal; blood clots in veins or lungs; need for transfusions; need for re-operation; stroke; and death from known or unknown causes. Any of these may require or result in additional invasive and/or surgical procedures. Other risks of this procedure may include**_____

_____

☐ **I consent** ☐ **I do not consent** to the administration of blood or blood products as deemed necessary by my physician(s). I understand there are risks inherent in every blood transfusion. These risks and alternatives to blood transfusion have been explained to me.

I consent to the disposal by the hospital of any tissues or parts which may be removed; to the use of medical photography during my operation or procedure if such is desired by my physician; to the release of my social security number for the purposes of tracking any implantable device; to the admittance of qualified observers to the surgery or procedure as determined collaboratively between my physician and the hospital.

I understand that during the course of the operation or procedure unforeseen conditions may be revealed which necessitate an extension of the procedure or a different procedure. If such a situation arises, I request that my physician perform such operations or procedures deemed appropriate in his/her professional judgment.

I hereby consent and authorize my physician and his/her assistant(s)/associate(s) to perform this surgery or procedure. I have been advised that qualified medical practitioners who are not physicians may perform such tasks as assisting my physician to dissect, remove or alter tissue, harvest grafts, or implant medical devices. I further authorize my physician(s) to arrange for services including but not limited to anesthesia, pathology, and imaging as needed for my care, and for the administration of whatever anesthetics or contrast materials as may be considered necessary by my physician. I certify this form has been fully explained to me, I have read it or have had it read to me and I understand its contents.

_____

Signature of Patient/Parent/Guardian/Surrogate/Proxy Date/Time am/pm

_____ _____

If other than patient, indicate relationship to patient Witness to Signature Date/Time am/pm

I hereby certify that I have fully explained the risks, benefits and alternatives of the procedure(s) listed above and answered fully all of the questions posed by the patient or the patient's representative prior to this procedure.

_____

Signature of Physician Date/Time am/pm

Lawnwood Regional Medical Center
Fort Pierce,FL
Surgery Generic

Patient Information Label

TREAT