SURGICAL INFORMED CONSENT FORM

CONSENT UPON ADMISSION FOR TREATMENT

I, _____, do voluntarily consent to the following medical procedure(s):

_____

_____

_____

Treating Doctor and Facility. The procedure will be performed by my Physician, Dr. _____, at Center For Reconstructive Surgery. I have been informed that there are physicians who may have ownership in this surgery center. I understand that I am free to choose another facility in which to receive services. I also understand Center For Reconstructive Surgery is arranging for the equipment, technical support and clinical staff to be used in performing this procedure.

Basis of Consent. I give this voluntary consent after discussing with my Surgeon and agree that the procedure is an appropriate course of medical treatment. In particular I have discussed with my Surgeon my general medical condition and allergies and I have informed The Surgeon about any medication (including prescription and over-the-counters medications) that I am currently taking. My Surgeon has fully explained the following:

- the nature and purpose, the material risks, benefits, possibility of complications, alternative treatments and procedures available and the consequences of the procedure.

I know that I may make requests for additional information about any of the above issues prior to the commencement of the procedure. I also know medicine and surgery are not exact sciences and that no guarantees can be made concerning the results of the procedure. My Surgeon has obtained my informed consent to the procedure. If I should have any questions or concerns regarding the nature or results of the procedure or any other examination or treatment, I understand that I should ask my Surgeon.

Consent for Additional Procedures. I also give voluntary consent for any necessary routine diagnostic procedures and medical treatment performed by my Surgeon as part of the above medical procedure. I also consent to the performance of other unforeseen operations or procedures if my Surgeon determines they are required. Such a situation may arise, for example, if the procedure or surgery discussed above discloses a previously unknown condition and my Surgeon determines, based on medical judgment, the unforeseen operation or procedure is reasonably necessary to improve or maintain my health. I also understand other necessary medical professionals, designated by my Surgeon, may also participate in my procedure.

Anesthesia. I understand that certain risks and benefits of anesthetics and medications. My Surgeon has explained to me that this procedure will be conducted while I am under one of the following types of Anesthesia:

- **General Anesthesia** (medicine administered to render the patient unconscious)
- **Monitored Anesthesia** (sometimes referred to as “conscious sedation” in which the patient is conscious but fully sedated)
- **Regional Anesthesia** (numbing of a large portion of the body often through injection of medicine)
- **Local Anesthesia** (medicine given to temporarily stop the sensation of pain in a small, particular area of the body)
- **Topical Anesthesia** (commonly administered through eye drops or cream applied to the skin)

The risks and benefits of this type of anesthesia as well as the alternatives to receiving the recommended anesthesia have been explained to me. I consent to the administration and performance of such anesthesia, and the administration of other necessary or advisable medications, under the direction of the physician who is responsible for this service. I understand the anesthesiologist or CRNA performing the anesthesia services has been granted privileges to provide these services at Center For Reconstructive Surgery but may not be an employee of Center For Reconstructive Surgery or any affiliates.

Transportation and Care After the Procedure. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home and provide assistance following my surgery. I acknowledge that I have been advised not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my procedure or as directed by my Surgeon.

Educational Use Authority. I give permission for medical data concerning my procedure and subsequent treatment to be used in clinical teaching by the Surgeon and others participating in my procedure and give permission to the photographing, videotaping or televising of my surgery for teaching purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them. For the purpose of advancing medical education, I consent to the admittance of observers approved by the Facility’s Director in the operating room. Under supervision of my Surgeon, I authorize clinical coaching of personnel in relation to my patient care.

Disposal of Medical Tissue. I consent to the disposal of any tissue removed during the procedure in accordance with customary practices.

_____
Pt. Initials

Additional Testing of Blood. In the event someone associated with my procedure becomes accidentally exposed to my blood or bodily fluids – such as in the case of an accidental needle stick or direct contact with their skin or mucous membrane with my blood or bodily fluids – I consent to the testing of my blood for blood-borne pathogens, including HIV and Hepatitis.

Advance Directives. I understand that advance directives are not honored at Center For Reconstructive Surgery.I understand that if an emergency medical condition should occur I will be transferred to the closest hospital for further evaluation and treatment. if I have an advanced directive or living will, the surgery center will still transfer me to a hospital which will make the decisions about following any advanced directive or living will. If I should be transferred to a hospital, I authorize to the hospital to release copies of my medical records to the surgery center to review the episode of care.

I have the following:	Copy given to SurgeryCenter
[ ] Living Will	[ ]
[ ] Health care surrogate, proxy or durable power of attorney [ ]	
[ ] Power of Attorney	[ ]
[ ] Evidence of Guardianship	[ ]
[ ] None	

Legal Relationship between Surgery Center and Physicians. I understand that all physicians furnishing services to the patient, including mySurgeon, an anesthesia provider, radiologist and pathologist are independent contractors with the patient and are not employees or agents of Center For Reconstructive Surgery . I understand that I am under the care and supervision of my Surgeon and that the surgery center and its staff carry out instructions of my Surgeon.

Radiology and Lab Services. . My Surgeon may also send specimens to a professional pathology laboratory for a pathological diagnosis. Pathology services are billed separately by those individual laboratories.

Equipment/supplies. I understand that my Surgeon may choose to prescribe additional supplies or equipment which may be billed separately.

Personal Effects. I release Center for Reconstructive Surgery from any responsibility for loss or damage to. money, jewelry, or other personal effects that I bring into Center for Reconstructive Surgery .

I acknowledge that I have received the following items prior to the procedure:
Patient Rights and Responsibilities Physician ownership information.
The policy about advanced directivesPatient Privacy

I CERTIFY that I have been given enough time to read and fully understand the above information that the procedure has been fully explained by my Surgeon and I authorize and consent to the performance of the procedure.

Patient's Signature **Printed Name** **Date & Time**

If patient's personal representative, state relationship and authority:

Representative's Signature **Relationship** **Printed Name** **Date & Time**

Witness' Signature **Printed Name** **Date & Time**

Physician's Signature **Anesthesiologist/CRNA (if Applicable)**

I have reviewed the anesthesia stated and procedure risks for this patient and for this procedure.

_____
Pt. Initials