Bayonet Point Surgery & Endoscopy Center

PATIENT INFORMED CONSENT

I, the undersigned, do hereby authorize Dr. _____ and / or such assistants as may be selected by him / her to perform the following surgical procedure{s):

_____

_____

upon_____(Name of Patient or Myself)

1. ***UNDERSTANDING***: The procedure(s) listed above has been fully explained to me and I fully understand the nature of the procedure as well as the risks, benefits, and alternatives to the proposed surgery. I understand that surgery is not an exact science and no guarantees have been made to or implied to me.
2. ***RISKS:*** I understand that any surgical procedure carries inherent risks. These risks include but are not limited to risks from anesthesia (including death), perforation, puncture, laceration or cut to organs or tissues, significant infection, bleeding and tooth damage. It is impossible to list every possible complication so the above lists are incomplete.
3. ***ADDITIONAL PROCEDURES***: If my doctor discovers a different, unexpected condition during my surgery, I authorize him / her to perform such additional or different procedures as considered necessary or advisable.
4. ***DRUGS AND ANESTHESIA***: The administration of drugs and anesthesia, even local anesthesia, involves risks including rare risk of death due to unusual reaction. I consent to the use of such drugs as may be necessary under the direction and supervision of the anesthesiologist / surgeon.
5. ***BLOOD, TISSUES, BLOOD PRODUCTS***: I authorize and consent to any blood test (except HIV) or specimen / tissue evaluations deemed necessary by my surgeon or anesthesiologist. I understand that the surgery center may retain, preserve, or dispose of any specimens / tissues removed from my body in accordance with usual and customary practice. I consent to the transfusion of blood or blood products if necessary.
6. ***PHOTOGRAPHS:*** I consent to the photography / videotaping of my surgical procedure and for the use of these in medical education, publication, and / or research, provided I would not be identified by name.
7. ***TRANSFER TO ANOTHER FACILITY***: I understand that the surgery is intended to be performed on an outpatient basis. I consent to my transfer to a hospital or other healthcare facility should my physician(s) deem it advisable or necessary. I also authorize the surgical center to arrange transfer including release of my medical record.
8. ***OBSERVERS***: With the approval of my physician, I consent to the admission of observers (such as medical students) in the operating room for the purpose of advancing medical and nursing education, as well as persons required for technical support.
9. ***TRANSPORTATION***: I understand that I am scheduled to go home after surgery and I must have a responsible adult drive me home.
10. ***ADDITIONAL INFORMATION***: _____

_____

I HAVE READ (or it has been read to me) AND UNDERSTAND THIS CONSENT FORM. ALL MY QUESTIONS HAVE BEEN ANSWERED. I FREELY CONSENT TO THIS SURGERY.

Patient Signature_____Date_____Time_____

Parent/Guardian Signature_____Witness_____

Reason patient unable to sign:_____

I certify that I fully explained the operation(s) and / or procedures and medical alternatives to the patient and answered all questions asked by the patient. _____ _____ Physician's Signature Date	

1. Modern anesthesia is relatively safe and uneventful, so that virtually, everyone can be offered its benefits. Most operations can be performed utilizing general anesthesia, regional anesthesia (such as epidural, saddle block, spinal, bier block, intravenous sedation) or combinations of these methods of anesthesia. The type of anesthetic drug(s) and technique(s) will be decided by your anesthesiologist, and the choice and any medically acceptable alternatives will be discussed with you. Every type of anesthesia has certain risks and hazards, which are known by your anesthesiologist. Unexpected reactions and complications may occur, however, and vary between patients where medical conditions appear otherwise similar.

2. Risks and hazards which are recognized by anesthesiologists as substantial and which may occur regardless of experience, care and skill of the anesthesiologist/anesthetist include, but are not limited to: broken teeth, allergic reactions, sore throat, awareness under anesthesia, hoarseness, pneumonia, phlebitis (inflammation and Infection of the veins), nerve injury or paralysis, damage to or failure of the heart, liver, kidneys and/or brain, and death. In most cases, these risks and hazards are rare. Your anesthesiologist or anesthetist will do his/her best to protect your from such risks and hazards, but no guarantee as to outcome of anesthesia can be made.

3. Conscious Sedation is a minimally depressed level of consciousness during which the patient retains the ability to maintain a continuously patent airway and respond appropriately to verbal commands or tactile stimulation. Conscious Sedation is intended to minimize anxiety and discomfort while reducing undesirable autonomic responses to painful stimuli.

4. Risks associated with Conscious Sedation include, but not limited to allergic reactions, loss of airway, respiratory/cardiac depression and possibly death. In most cases, these risks are rare, however no guarantee as to outcome of conscious sedation can be made.

5. M.D., Anesthesiologist, provides anesthesia and/or C.R.N.A.'s (Certified Registered Nurse Anesthetists) to provide total anesthesia care for you.

6. I consent to the administration of anesthesia/conscious sedation and to the use of such anesthetic agents as may be deemed necessary and advisable by the physician responsible for this service, with the exception of : _____
(none, spinal, epidural, other)

7. I understand that the type of anesthesia/conscious sedation will be chosen by the anesthesiologist or anesthetist who administered the anesthetic, and that it may be changed, if necessary, except as specified in the above paragraph.

8. I have read the above statements and I request that I be given anesthesia/conscious sedation for my operation/procedure.

Patient Signature: _____ Date/Time: _____

Person giving consent if other that patient: _____

Relationship to patient: _____

Witness: _____ Date/Time: _____

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Patient ID