PALOUSE
Surgery Center

Informed Consent for Operation, Diagnostic or Therapeutic Procedure, and Anesthesia

Name of Patient: _____

I hereby authorize and direct Doctor _____ and such assistant, vendor, student, or other observer as may be approved by said

physician, to observe or participate, to treat the following condition: _____

_____

The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand them to be: _____

_____

My surgeon has discussed the proposed operation with me and I understand what he hopes to accomplish with it, as well as the risks involved.

IT HAS BEEN EXPLAINED TO ME THAT A SATISFACTORY RESULT IS EXPECTED, BUT THAT THE FOLLOWING ARE SOME OF THE COMPLICATIONS OR EFFECTS THAT COULD OR MAY OCCUR: BLEEDING, INFECTION, DAMAGE TO ADJACENT TISSUES OR ORGANS, SWELLING, PAIN, SUTURE REACTION, DELAYED HEALING, SCARRING, ANESTHESIA OR MEDICATION REACTION, RECURRENCE, ADDITIONAL OPERATIONS, AND IN RARE INSTANCES, PARALYSIS OR DEATH.

I understand that during the operation unforeseen conditions may make it necessary to perform additional or different therapeutic procedures other than those stated above. This may also include pathology or radiology services. I thereby authorize the above named physician to perform or authorize those procedures or services deemed necessary or advisable in his judgment. I acknowledge that no warranty or guarantee has been named to me as to result or cure.

I consent to the administration of anesthesia by the attending physician, anesthesiologist or certified registered nurse anesthetist as may be deemed necessary. I understand that all anesthetics involve some risk of damage to vital organs such as the brain, heart, lung, liver, and kidney and that in some rare cases may result in paralysis, cardiac arrest, or death.

I give permission for any tissue surgically removed to be examined by a pathologist and to be retained or disposed of by the laboratory as to accustomed and required standards of practice. I consent to photographic documentation of the procedure or specimens obtained at the time of the operation/procedure.

I agree to the transfusion of blood and/or blood products if deemed necessary by my physician. I recognize that the use of blood or blood derivatives carries risks including hepatitis, AIDS, and transfusion reaction.

I will remove, and take responsibility for all prosthetic devices, such as glasses, contact lenses, dental and hearing prosthesis if so directed. I shall not hold Palouse Surgery Center liable for loss or damage to any money or article of value.

I understand it is my responsibility to have a responsible adult present to drive me home after my procedure.

INFORMED CONSENT

I certify that my physician has informed me of the nature and character of the medical procedure or surgery described on this form, including its possible significant risks, complications, and anticipated results; and the alternative forms of treatment, including non-treatment, and their significant risks, complications and anticipated results. I CERTIFY THAT THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I HAVE READ IT OR HAVE HAD IT READ TO ME, AND THAT I UNDERSTAND ITS CONTENTS.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON _____

RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON TO PATIENT_____

WITNESS _____ DATE _____ TIME _____

PHYSICIAN_____