

CONSENT TO OPERATION/PROCEDURE Jupiter Outpatient Surgery Center, Jupiter, FL 33458

Patient: _____

I hereby authorize Dr. _____ and whomever he/she may designate as his/ her assistants, to perform upon _____ the following operation or Procedure _____
(State name of patient or myself)

_____ and if any unforeseen condition arises in the course of the operation/procedure calling in his judgment for procedures in addition or different from those now contemplated, I further request and authorize him/her to do whatever is deemed advisable.

1. _____ The doctor has explained the nature of this operation/ procedure. I understand that all procedures involve risks and the possibility of complications occurring during the preoperative or procedural and recuperative period, such as allergic reactions, infections, blood vessel occlusions; heart rhythm disturbances; unplanned injuries to organs, nerves, or blood vessels to include inadvertent puncture; laceration; a tearing of other internal organs, and consequent hemorrhage. Some of the complications of this procedure can cause the need for further major surgery or treatment. Some of the complications can cause poor healing wounds, paralysis, acute or prolonged illness, and permanent deformity; very rarely, some of the complications can even be fatal. The doctor has explained the expected benefits and likely outcomes if complications occur. The doctor has also explained relevant options, as well as the risks of not having the procedure. I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at the surgery center.
2. _____ I consent to the administration of anesthesia by or under the direction of a fully qualified anesthesiologist or his/her designee and the use of such anesthetics as may be deemed advisable; to the administration of blood and blood products.
3. _____ In the ambulatory setting, if a patient should suffer a life threatening situation during the perioperative period, this signed consent implies consent for resuscitation and transfer to higher level of care. Therefore Jupiter Outpatient Surgery Center staff will not honor previously signed Advance Directives for any patient. If you disagree, you must address this issue in advance with your physician prior to signing this form. (Perioperative is used as an all encompassing term to begin the moment the patient enters the preoperative area to the Operating Room and ends upon discharge from the Recovery Room.)
4. _____ I consent to the administration of medications or intravenous fluids that may be deemed necessary during the course of the procedure. I also consent to the performance of laboratory testing and diagnostic procedures including fluoroscopy as deemed necessary in my diagnosis and treatment.
5. _____ I consent to the disposal by authorities of Jupiter Outpatient Surgery Center, LLC of any tissue or parts which may be removed.
6. _____ I consent to the taking and publication of photographs or videotaping in the course of this procedure for the purpose for the advancement of medical education provided my identity is protected.
7. _____ I consent to the admittance of an observer to the operating room for the purpose of advancement of medical education including students who have had prior approval of the Administrator or Clinical Coordinator; and to the presence of a medical representative in the operating room.
8. _____ I received the Patient's Bill of Rights and Responsibilities, Advanced Directives, and Disclosure of Ownership notices prior to my scheduled procedure.
9. _____ I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
10. _____ I certify that I have read and fully understand the above consent to operation/procedure; that the explanations there referred to were made; and that all blanks or statement requiring insertion or completion were filled in, and inapplicable paragraphs, if any were stricken before I signed. On the basis of the previous statements, I REQUEST TO HAVE THE PROCEDURE.

Patient Signature: _____ Date: _____ Time: _____

When a patient is a minor or incompetent to give consent:

_____ Date: _____ Time: _____
Signature of Person Authorized to Sign for Patient

Witness: _____
(To Signature Only)

To be Completed By Procedural Physician on Day of Procedure

I have explained the patient's condition, the need for treatment, the benefits of the procedure and the risks involved; relevant treatment options and their risks, likely consequences if those risks occur; the significant risks and problems specific to this patient; and the likelihood of success for this procedure and patient. I have reassessed the patient with the following findings.

_____ **Patient examined and no changes from previous assessment** _____ **Patient examined and changes from previous assessment documented on progress note**

Procedural physician Signature: _____ Date: _____ Time: _____