

Rivertown Surgery Center
Consent to Operation, Anesthetic
and other Medical Services

1. I authorize the performance upon _____ of the following
(Patient's name)

Operation _____

to be performed by Dr. _____ and such associates as may be selected by him/her to perform such operation.

2. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures or services than those set forth above and I further authorize and request the above-named surgeon and/or his/her associates, partners, assistants or designees perform such procedures as his/her professional judgment deem necessary and desirable.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service. I understand that anesthesia involves additional risks and hazards and I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I realize the anesthesia may have to be changed without explanation to me. I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage and even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, eyes, or teeth. The type of anesthesia I will receive is _____. Pt. initials: _____

4. The nature and purpose of this operation has been explained to me including possible alternative methods of treatment. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, therapeutic and/or diagnostic procedure planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for pain, infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I am willing to accept these risks. No guarantee or assurances have been given by anyone as to the results that may be obtained by the medical treatment or services rendered to me.

5. I understand the nature of the proposed procedure(s) and attendant risks as described above. I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. I, the undersigned, have had this form explained to me and fully understand the contents of this authorization.

6. Advanced directives are honored prior to the onset of anesthesia. However, once anesthesia is administered, the patient will be fully resuscitated, unless prior arrangements have been made with health care provider. The patient's advanced directives are reinstated after the patient is discharge from this facility.

Patient or authorized person

Witness to signature

Relationship

Date