



Patient Name:
Surgeon:
Date of Service
Medical Record:
Date of Birth:

PATIENT CONSENT TO PROCEDURE

Your physician, _____ has determined that the operation or procedure listed below may be beneficial in the diagnosis or treatment of your condition. All surgical operations and diagnostic and therapeutic procedures involve risks of unsuccessful outcomes, complications, injury or even death, from both known and unforeseen causes. No warranties or guarantees have been made as to result or cure.

Operation or procedure to be performed _____

Your treating physician may be an independent contractor and therefore is not an employee of Crown Valley Outpatient Surgical Center ("Center"). Independent contractor physicians also provide anesthesia services at the Center and independent contractor nurse anesthetists (CRNAs).

As a patient you have the right to receive as much information as you may need in order to give informed consent or to refuse the recommended course of treatment. Except in emergencies, your healthcare provider should describe in language you can understand, the nature of the ailment and the or nature of the proposed treatment or procedure, the material risks or dangers involved, the alternate courses of treatment nontreatment, including the respective risk of unfortunate consequences associated with the treatment or procedure, and the relative probability of success of the treatment or procedure. If you have questions, you are encouraged and expected to consult your healthcare provider prior to giving your consent to such operation or procedure. You have the right to consent or refuse any proposed operation or procedure prior to its performance.

Having read and fully understanding the above, and having received and fully understanding the above information from my physician(s) and/or podiatrist(s), I hereby authorize the following:

- 1. I authorize the above-named healthcare provider and any of their associates or assistants, including residents within their licensed scope of their practice, to perform the above named procedure and to provide such additional services as may be deemed medically reasonable and necessary, including but not limited to:
a. Those resulting from conditions or discoveries, which make a change or extension advisable;
b. The administration of anesthesia by a healthcare professional including local anesthesia by the surgeon;
c. The implant of medical devices
d. Services involving pathology and radiology;
e. Transfer to a hospital and issuance of the hospital's discharge summary to the Center.
2. I authorize the pathology services to use its discretion in the retention or disposal of any severed tissue or member.
3. I understand that, if given other than local anesthetic, I am required to have a responsible adult available during and after my surgery and that I will be discharged to that person's custody and must rely on him or her for my return home.
4. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Center may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Center's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purposes of medical quality assurance/improvement and peer review.
5. I authorize disclosure of my Social Security number to device manufacturers subject to the Safe Medical Device Act.
6. I have received verbal and written notification of the Center's patient rights, advance directives and ownership prior to today and understand that this facility respects human life and will not follow any advance directives that may be in place.
7. Your treating physician may have an ownership interest in the Center and may gain financially by performing the procedure at the Center. You, the patient, have the right to choose where your procedure is performed. By signing this consent, you are agreeing to have the procedure performed at Crown Valley Outpatient Surgical Center.

I certify that I have read and fully understand the above consent statement, that the explanations herein referred to are understood by me, that all my questions have been answered, that all blanks or statements requiring insertion or completion were filled in prior to the time of my signature, and that this consent is given freely, voluntarily and without reservation. I understand that I have the right to refuse any medical and surgical procedures and treatment.

X _____
Signature of Patient/Date

Person Legally Authorized To Consent for the Patient

Witness/Date

Relationship, If Other Than Patient Signing

Attending Physician/Surgeon



Patient Name:
Surgeon:
Date of Service
Medical Record:
Date of Birth:

PATIENT CONSENT TO ANESTHESIA

I understand that:

- I will need anesthesia services for the surgical procedures(s) to be done on (date), and that the type of anesthesia to be used will depend upon the procedure and my physical condition.
Anesthesia is a specialty medical service, which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a medical, surgical, or obstetrical procedure.
During the course of the surgical procedure, conditions may require additional or different anesthetic monitoring or techniques, and I ask that the anesthesiologist provide any other necessary services for my benefit and well being.
In addition to the anesthesiologist whose name appears on this document, my anesthetic services may be provided by another anesthesiologist.
No guarantees have been made by anyone regarding the anesthesia services, which I am agreeing to have.

Type Of Anesthesia And Definitions

General anesthesia

- Endotracheal anesthesia: anesthetic and respiratory gases are passed through a tube placed in the trachea (windpipe) via the nose or mouth.
Mask anesthesia: anesthetic gases are passed through a mask that covers the nose and mouth.

Regional anesthesia

- Epidural anesthesia: a small catheter is inserted into epidural (spinal) space so that anaesthetizing agents may be given to prolong the duration of anesthesia, or medications given in single injection into epidural space.
Spinal anesthesia: the anesthetic agents are injected into specific areas to inhibit nerve transmission.
Caudal anesthesia: anesthetic medications are given into the tailbone area.

Nerve blocks:

Sympathetic (cervical, thoracic ganglion and lumbar sympathetic block); anesthetic medications given in the neck, chest and back to relieve pain.

Monitored Anesthesia Care (MAC):

Includes the monitoring of at least blood pressure, oxygenation, pulse and mental state, and supplementing analgesia as needed.

Risks and Complications may include but are not limited to: allergic/adverse reaction, aspiration, backache, brain damage, comas, dental injury, headache, inability to reverse the effects of anesthesia, infection, localized swelling and/or redness, muscle aches, nausea, ophthalmic (eye) injury, pain, paralysis, pneumonia, positional nerve injury, recall of sound/noise/speech by others, seizures, sore throat, wrong site for injection of anesthesia, and death.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent. I agree to the administration of the anesthesia prescribed for me. I recognize the alternative to acceptance of anesthesia might be no anesthesia for the procedure.

(PATIENT'S SIGNATURE) (DATE) (TIME) (WITNESS SIGNATURE) (DATE) (TIME)
(PATIENT'S NAME - PRINT) (DATE) (TIME) (ANESTHESIA PROVIDER'S SIGNATURE) (DATE) (TIME)