Northlake Surgical Center

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REQUEST AND INFORMED CONSENT TO SURGICAL AND/OR DIAGNOSTIC PROCEDURES

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

Patient's Name: ______________________________ **Date:** ____________________

The following has been explained to me in general terms and I understand that:

1. **The diagnosis requiring this procedure is:** (Diagnosis described in layman's terms)
   ____
   ____
   ____

2. **The nature of the procedure is:** (Diagnosis described in layman's terms)
   ____
   ____
   ____

3. **The purpose of this procedure is:** (Specific for this patient)
   ____
   ____
   ____

4. **MATERIAL RISKS OF THIS PROCEDURE**
   As a result if the procedure being performed. There may be material risks of:

   INFECTION, ALLERGIC REACTION. DISFIGURING SCAR, SEVERE LOSS OF BLOOD, THE NEED FOR BLOOD OR BLOOD PRODUCT TRANSFUSION, LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.

5. **In addition to these material risks, there may be other possible risks involved in this procedure including, but not limited to:**
   ____
   ____
   ____

6. **The likelihood of success of the above procedure is:**
   Good ☐ **Fair** ☐ **Poor** ☐

7. **Practical alternatives to this procedure include:** ______________________________

8. **If I choose not to have the above procedure, my prognosis (future medical condition) is:**
   ____
   ____
   ____

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I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissues, specimens, organs or limbs removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other healthcare provider.

I also consent to the photograpnmg, videotaping and/or closed circuit televising, and publication thereof, of the operation(s) or procedure(s) to be performed providing the identity of the patient is not revealed and the use thereof is limited to medical, scientific or educational purposes. I waive all rights that I may have to claim, payments, royalties or other remuneration in connection with any exhibition of foregoing recording(s) .

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS. THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN.

I hereby voluntary request and consent to the performance of the procedures described or referred to herein by Dr. ______________________________ and any other physicians or other medical personnel who may be involved in the course of my treatment.

Anesthesia Plan: ☐ I.V. Conscious Sedation ☐ None ☐ Other: ____________________

Physician	Person Giving Consent
Witness	Relationship to Patient if not Patient
Date	Reason if Patient is Unable to Sign

Additional Materials used, if any, during the informed consent process for this procedure include:

____

____

Person describing consent: ____