

DCR SURGERY CENTER CONSENT FOR SURGERY

Patient Name: _____ ID# _____ Date: _____

I hereby authorize **Dr. Kumar** **Dr. Martinez** **Dr. Damallie** and such assistants as may be selected by said physician to treat the following conditions under Scheduled Anesthesia type **IV Sed** _____ **Local** _____. The procedure(s) planned for treatment of my condition(s) have been explained to me by my physician and are listed below: **Colonoscopy** _____ **Other:** _____

Possible risks associated with this procedure(s): **Infection, Swelling, Discomfort, Bleeding, Perforation of bowl, Other(s)** _____.

You have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge acceptance of treatment recommended by your physician. At any time you have the right to refuse or withdraw consent for treatment.

I certify that my physician has informed me of the nature and character of the proposed treatment, the anticipated results, the possible alternative forms of treatment and the recognized serious possible risks, complications and the anticipated benefits involved in the proposed treatment including non-treatment. I acknowledge that no warranty or guarantee has been made to me as to the results of my procedure or cure of my condition.

I recognize that (1) all procedures have basic risks and potential complications (2) if an incision is needed, infection or incisional pain can occur, and may require further treatments or procedures (3) the list of risks and complication of this form are not inclusive but list the more common or severe ones (4) during the course of the procedure, post-operative care, medical treatments, anesthesia, and unforeseen conditions may necessitate additional or different procedures other than those sent forth. I authorize my above physician, and assistants or designees, to perform such surgical or other procedures including but not limited to administration of moderate sedation/analgesia, as they deem necessary.

I have been advised by DCR Surgery Center personnel that I should not (1) Drive (2) operate any machinery/power tools (3) ingest alcohol within 24 hours of receiving moderate sedation/analgesia.

I acknowledge that even though the physician and staff of DCR Surgery Center respect my rights and decisions regarding my healthcare, the policy of DCR Surgery Center is all patients undergoing surgical procedures will be considered for life sustaining emergency treatments. **If you have advance directive please make it known to our staff and we will follow your request. Advance directive** _____yes _____no Copy provided_____

I authorize the surgery center; pathologist or physician in accordance with accustomed practice may dispose of any parts removed surgically. I consent to the presence of Medical Students and/or medical residents in the operation room as observers or assistant under the direct supervision of the Staff Physician for educational purposes.

Your signature below constitutes your acknowledgement (1) that you have read and agree to the foregoing: (2) that the procedures listed above have been adequately explained to you by the above named physician (3) that you authorize and consent to the performance of the procedures (4) that you authorize and consent to administration of anesthesia if applicable (5) that you authorize insurance benefits be made on your behalf to DCR SURGERY CENTER. After claim has been submitted you accept responsibility for any remaining balance after insurance payment.

(Physician/Guardian signature) Date: _____

Witness: _____
(Print Name Patient/Guardian signature) (Relationship of Guardian)

Signature of Responsible party (if other than self) _____

(The Person responsible to drive patient home) The medical procedure or surgery stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results, was explained by me to the patient or his/her representative before the patient or his/her representatives consented.

Date: _____
(Physician's signature)

