

CONSENT TO OPERATION, ANESTHETICS, AND OTHER MEDICAL SERVICES:

1. I authorize the performance of the following operation _____

 upon _____
 to be performed by or under the directions of Drs. _____.
2. My physician has fully explained to me the condition requiring treatment and the nature, purpose, risk and benefits of the operation(s)/procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications. I was given the opportunity to ask questions and any such questions were answered to my satisfaction. No guarantee or assurance has been given by anyone as to the results that may be obtained. I am aware that the practice of medicine and surgery is not an exact science.
3. I consent to the performance of operations or other procedures in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the operation.
4. I understand the risks, benefits, and alternatives to the type and method of anesthesia or sedation recommended, and I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician for this service with the exception of _____ anesthesia.
5. I understand that the physicians, anesthesiologists and/or podiatrists who participate in the operations or procedure are independent contractors and are NOT EMPLOYEES OR AGENTS OF the surgery center.
6. I understand this surgery center is owned by physician/surgeon investors who also perform procedures at the surgery center, and that I may ask my physician/surgeon or the center administrator for further details.
7. I consent to the photographing or videotaping of the operation or procedures to be performed including appropriate portions of my body for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.
8. I consent to the presence of observers in the operating room, e.g., students, medical residents, medical equipment representatives, or other appropriate parties approved by my surgeon.
9. I consent to the disposal by the surgery center authorities of any tissues or part which may be removed.
10. If complications arise, I agree to be admitted to the hospital of my surgeon's choice.
11. Surgical operations and special diagnostic or therapeutic procedures all involve RISKS OF COMPLICATIONS, SERIOUS INJURY OR EVEN DEATH, from both known and unknown causes. Except in cases of emergency or exceptional circumstances, these operations and procedures therefore will not be performed unless I have had an opportunity to discuss them with my physician. I have the right to consent to or refuse a proposed operation or special procedure.
12. I have been advised that there is a possibility of damage to teeth during surgery and administration of anesthesia, particularly if the teeth are weak, loose, decayed or artificial, and I waive any claim for damage to teeth as a result thereof.
13. I understand that the 77 Illinois Administrative Code, Chapter 1, Section 697.120, permits the surgery center to perform a blood test for HIV (the AIDS virus) on any patient during whose treatment a health care professional sustains a puncture, mucous membrane or open wound exposure to a patient's blood or other bodily fluids. A test for Hepatitis B and C may also be drawn.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGMENT:

1. THAT I HAVE READ, UNDERSTAND AND AGREE TO THE FOREGOING,
2. THAT THE PROPOSED OPERATION(S) HAVE BEEN SATISFACTORILY EXPLAINED TO ME AND THAT I HAVE ALL OF THE INFORMATION THAT I DESIRE,
3. THAT I HEREBY GIVE MY AUTHORIZATION AND CONSENT, AND
4. THAT ALL BLANK SPACES ON THIS DOCUMENT HAVE EITHER BEEN COMPLETED OR CROSSED OFF IF THEY DO NOT APPLY PRIOR TO MY SIGNING.

SIGNED

RELATIONSHIP TO PATIENT

WITNESS

DATE

TIME

SURGEON'S ATTESTATION: Prior to the procedure, I discussed the condition requiring treatment and the nature, purpose, risks, and benefits of the operation(s)/procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications with my patient or the patient's legally authorized representative. I gave them the opportunity to ask questions and answered any such questions to their apparent satisfaction. I have reviewed the surgical consent and verified the planned procedure is accurate. **Surgeon's initials:** _____