Eastside Surgery Center **CONSENT FOR OPERATIVE PROCEDURE**

1301 4th Avenue NW, Suite 201, Issaquah, WA 98027

1. **Operation/Procedure:** I request the performance of the following operation/procedure by the following physician and whomever she/he may designate as an assistant.

   Patient: _____ Provider: _____

   Operation/Procedure: _____

   _____

   _____

   I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

2. **Anesthesia:** Patients may respond differently to medication and anesthetic agents. Because of this and the stresses of the surgical procedure, unexpected and unpredictable reactions may occur under anesthesia and result in artificial ventilation, coma, or death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services.

3. **Additional Procedures:** I further authorize the performance of such additional operative procedures as the above named physician, during the course of the above named operation/procedure, may at such time determine to be advisable.

4. **Operative Complications:** This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include swelling and restriction of joint motion, infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia, and failure of the procedure.

5. **Observers:** Medical and healthcare students may be present in the operating room to observe or assist with your surgery. Individuals who are not health care providers, such as medical industry vendors and other individuals, may be present in the operating room to observe your surgery. You will be informed of their presence and purpose before your surgery. Do you consent to their presence? Yes _____ No _____

6. **Photography:** I consent to photography performed.

7. **I consent to video recording** of appropriate portions of my body for medical, scientific, or educational purposes, provided my identity is not revealed by pictures or descriptive texts accompanying them. Yes _____ No _____

8. **Specimens:** I consent to a pathologist's examination and/or destruction of any tissue specimen which may be removed by the above named physician in accordance with its policies.

9. **Nothing by Mouth**: I have had nothing by mouth to eat or drink for the designated time instructed.

9. **Informed Consent to Surgery or Special Procedure:** Your signature on this form indicates that: 1) You have read and understand the information provided in this form; 2) Your physician has adequately explained to you the operation or procedure set forth above, along with the risks, benefits, alternatives, and other information described above in this form; 3) You have had the chance to ask your doctor questions; 4) You have received the information you desire concerning the operation or procedure; and 5) You authorize and consent to the performance of the operation or procedure.

10. **Blood Test:** I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, except as specified by law.

11. **Pregnancy Test:** If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.

12. **Peer Review:** I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

13. **Discharge Instructions:** The responsible adult(s) accompanying me can be present during my discharge instructions, which may include a discussion of my private health information. _____
    Initials

_____

Patient/Legal Guardian Date and Time Relationship

_____ _____

If other than patient, state reason why Witness Date/Time

_____

Provider Date/Time

Patient Label