Patient Name _____

Date of Surgery _____

Scheduled at **PIEDMONT SURGERY CENTER**

Piedmont HEALTHCARE

INFORMED CONSENT TO SURGICAL, DIAGNOSTIC, THERAPEUTIC PROCEDURE(S) OR IMPLANTATION OF TISSUE OR PROSTHETIC DEVICES

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

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

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

1. The diagnosis requiring this procedure(s) is: _____

2. The procedure(s) is/are: _____

3. The nature and purpose of this procedure(s) is/are: (specific for this patient) _____

4. Practical alternatives to the above procedure(s) and their risks and benefits are: ☐ None ☐ Other

5. Significant risks of this procedure(s) being performed may include: PAIN, INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OF ANY LIMB OR ORGAN OR LOSS OF ITS FUNCTION, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH. Other possible risks of this procedure(s) include, but are not limited to: _____

6. The likelihood of success of the above procedure(s) is: ☐ Good ☐ Fair ☐ Poor ☐ Unknown

7. If I choose not to have the above procedure(s), my prognosis (future medical condition) is: ☐ Good ☐ Fair ☐ Poor ☐ Unknown

8. I hereby voluntarily request and consent to the performance of the procedure(s) described/referenced herein by _____, M.D. and such other physicians, including but not limited to residents under his/her supervision or other qualified medical professionals as are needed to assist him/her to perform the procedure(s). I understand that these practitioner(s) will assist him/her in performing the procedure(s) and that the practitioner(s) will perform only tasks that are within their scope of practice and privileges and in accordance with hospital policies. I understand that not all practitioner(s) may be known at the time this consent is given. I consent to and authorize the physician to involve those practitioner(s) he/she deems necessary to perform significant surgical tasks, including, but not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissues.

9. I understand that during the course of the procedure(s), unforeseen conditions may arise that require an extension of the original procedure(s) or different procedure(s) from what is listed in Paragraph 2. I request that the physician named in Paragraph 8 and/or his/her assistant or designee, perform under his/her supervision, the procedure(s) that appear necessary in their judgment. The authority granted under this Paragraph 9 extends to treating all conditions that require treatment but are not known at the time the procedure(s) is started.

10. I consent to the administration of anesthesia/IV sedation under the supervision of my physician or the anesthesiology group and to the use of such anesthetics as may be deemed advisable. If appropriate, sedation has been explained to me as the administration of a drug or drugs that will depress consciousness during a surgical/diagnostic procedure. The risks of sedation including, but not limited to, heart attack and cessation of breathing, have also been explained to me, as have the alternatives to sedation, which are the administration of local anesthetics, oral pain medications or no sedation at all.

11. I consent to the use of a direct arterial, central venous, or pulmonary artery catheter(s) if my physical condition, or the nature of the procedure(s), necessitates such use.

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

12. I consent to diagnostic studies, tests, fluoroscopic examinations and any other treatment or courses of treatment relating to the diagnosis or procedure(s) described herein.

13. *I consent that any tissues, specimens, organs, limbs or parts removed from my body in the course of any procedure(s) may be retained by, preserved, tested and/or disposed of within the discretion of Piedmont Surgery Center and its agents or employees.

14. *I consent to the photographing, and/or audio-visual recording including appropriate portions of my body, to be used only for prior-stated reasons of my choice.

15. *I consent to the presence of observers during my procedure(s) as approved by my physician for medical or educational purposes, or other reasons of my choice.

16. *The FDA has ordered that manufacturers track any medical device that I may receive. I understand that I may refuse permission to release my name, address, telephone number, and social security number or other identifying information to the device manufacturer. I understand that by refusing permission to release my confidential information to the manufacturer, one or more things may happen: I could be required to reschedule my surgery; there could be a delay in my being contacted if a possible problem with the device should become known. I understand that such a delay could negatively impact my health.

17. I am aware that the practice of medicine and surgery requires the use of disposable and non-disposable equipment and instrumentation that may or may not be reprocessed by a third party vendor as required by the FDA.

18. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me about the procedure(s) or the results of the procedure(s).

19. Some of the healthcare professionals performing services in this facility are independent contractors and are not Piedmont Surgery Center employees. Independent contractors are responsible for their own actions and Piedmont Surgery Center shall not be liable for the acts or omissions of any such independent contractors.

PATIENT INFORMED CONSENT

By signing this form, I acknowledge that the risks, benefits and alternatives to the above procedure(s) have been explained to me and that I have read or had this form read and/or explained to me in general terms, that I fully understand its contents, that I have been give ample opportunity to ask questions and that any questions have been answered or explained 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, material relating to the procedures(s) described herein.

I REQUEST AND CONSENT TO THE PERFORMANCE OF THE PROCEDURE(S) AS OUTLINED ABOVE.

_____ Date: _____ Time: _____ _____

Signature of Patient / Authorized Representative (please circle one) *If not patient, relationship to patient*

Name of person giving consent (print) _____ Patient unable to sign because: _____

Witness (print): _____ Signature: _____ Date: _____ Time: _____

*If patient does not wish to consent to items no. 14, 15, and/or 16, he/she may line through and initial/date/time any or all. Such action may delay procedure or necessitate further discussion with your physician.

RESPONSIBLE PHYSICIAN STATEMENT

I have reviewed the contents of this form, including risks, benefits and alternatives to the proposed procedure(s), with the patient and/or patient's authorized representative. I have provided an opportunity for questions and answered any that were asked. The patient and/or patient's authorized representative has indicated understanding and consented to the procedure described above.

Practitioner (print): _____ Signature: _____ Date: _____ Time: _____