SURGICAL OR DIAGNOSTIC PROCEDURE CONSENT

Patient Name: _____ Date of Procedure(s):_____

Diagnosis: _____

Scheduled Procedure(s):_____

I, the above-named patient (or guardian), hereby authorize **Dr. BOYD PARIKH SHIH** (the surgeon) and/or health care providers other than the primary surgeon/practitioner named above, including physician(s), fellow(s), resident(s), physician assistant(s), and/or registered nurse first assistant(s), to perform the procedure(s) noted above on me/the patient. If any unforeseen condition or situation arises or becomes known to him/her in the course of carrying out the procedure(s), I authorize the surgeon and/or his associates and/or assistants to provide additional services as they may deem necessary or advisable. I also understand and acknowledge that the health care providers listed above and who may be scheduled to participate in the procedure(s) may change before or at the time of the procedure(s).

I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The nature and purpose of the procedure(s), possible alternative treatments, the risks involved and the possibility of complications including but not limited to infection, bleeding, allergic reaction, blood clots in the veins and lungs, stroke, kidney failure, cardiac arrest, need for additional surgery and even death or disability, have been fully explained to me by my doctor and/or his/her staff. I have been informed of the risks and benefits of being cared for at the Center versus a hospital. I understand that the Center does not provide overnight or 24 hour care and I may need to be transferred to a local hospital for further evaluation and/or admitted if my physician/anesthesiologist deems it necessary. Risks specific to the above procedure may include:

BLEEDING, IMMEDIATE OR DELAYED; INFECTION; URINARY RETENTION; RECURRENCE OF SYMPTOMS; UNSATISFACTORY OR UNANTICIPATED RESULTS

I consent to the performance of physical examinations and routine diagnostic procedures, and to the injection or other administration of pharmaceutical agents incidental to my/the patient's procedure(s). I consent to the administration of anesthetics to be administered by or under the direction of my physician. In the administration of sedation/analgesia the risks, benefits, and alternatives have been explained to me. I

I consent to the taking of photographs of films during the course of the procedure(s) for the purpose of education, research, and/or documentation of my medical condition in the medical record. I understand that my identity will not be revealed if the photographs or films are used for medical education or research, and in all instances, patient confidentiality will be preserved. I understand that copies of the prints will be given to me if I ask for them. In addition, I consent to the presence of observers and/or students during the course of the procedure(s) for the purpose of advancing medical education.

I consent to the presence of health care industry representatives designated by the physician during the course of the procedure(s) to provide technical support for the equipment that may be used during the procedure(s).

I understand that the facility has a policy on advanced directives which states that life sustaining efforts will be initiated and maintained on all patients.

Should I require the implantation (surgical placement) of a medical device, I give the facility permission to release my Social Security number to the manufacturer of the device in order to assist the manufacturer in contacting me about the device if such contact becomes necessary.

I have been informed that previously used medical devices that have been reprocessed in accordance with Food and Drug Administration (FDA) standards may be used during the course of my surgical/medical treatment, and I consent to the use of such devices.

My physician has discussed with me any limitations on the confidentiality of information learned from or about me.

By my signature below, I certify that I have read and fully understand this document, that any explanations requested were made, and that all blanks or statements requiring insertion, striking or completion were filled-in or stricken before I signed. I voluntarily and freely consent to the proposed procedure(s).

_____ _____

Signature of Patient or Authorized Representative Date Time ❒ AM ❒ PM Relationship to Patient

_____

Signature of Witness Date

_____

Signature of Physician/Practitioner who explained the procedure(s) to the Patient/Authorized Representative Date

Patient Label