Vein & Vascular Experts

Dr. Gus De Jesus

Board Certified Vascular Surgeon

5907 Hillside Heights Dr.

Lakeland, FL 33812

SURGICAL CONSENT

Patient Name:_____ **DOB:** _____

I hereby authorize and direct Dr. Gustavo DeJesus, MD, and/or associates of his/her choice to perform the following operation(s) or procedure(s):

_____

_____

For treatment of my condition which has been described to me as:

_____

Risks of the procedure have been described to me as:

_____

I hereby authorize and direct the above named physician or other physician and/or associates and assistants to provide or arrange for the provision of such additional services that are deemed necessary or advisable, including, but not limited to, intra-procedural conscious sedation to be administered by a registered nurse (under physician direction) and radiological services. I understand a choice of alternative anesthesia and anesthesia provider exists, but is not available at this location.

All operations and procedures involve risks, such as unsuccessful results, complications, injury, or even death, from known and unforeseen causes. I have the right to be informed of such risks, as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. I also have the right to be informed whether my physician has any medical research or economic interests related to the performance of the proposed operation or procedure. I have the right to receive this information and to give my consent before operations or procedures are performed. I have the right to consent to or to refuse any proposed operation or procedure at any time prior to its performance. No warranty or guarantee is made as to the result or cure.

Although I have been given an opportunity to be advised of the nature and purpose of the operation or procedure, and the risks, benefits, and alternatives, I specifically decline to be so advised, but I do give my consent to the operation. No warranty or guarantee has been made as to the result or cure.

I understand that there may be health care industry manufacturing representatives or other visitors present in the procedure room for the purpose of providing technical support during my procedure, and consent to this at the discretion and approval of the physician and office.

I consent that photographs, movies or videotapes may be taken of me to be used for the medical records and publications (in print or by broadcast) for the purpose of medical education private or commercial sponsorship, provided I am not identified by name. I waive all rights to claim for payment or royalties in connection with the above publication or broadcast.

I understand that my medical records may be used for chart review by the office.

I understand that the office does not honor advance directives.

My signature on this form indicates that :

I have read and understood the information contained herein;
I have been informed about this operation or procedure and the potential risks, benefits, alternatives and the risk of those alternatives' and
I authorize and consent to the performance of this operation or procedure

_____ _____

Signature of patient, parent or guardian **Relationship, if signed by other than patient**

_____ _____

Witness to signature **Printed name of witness to signature**

_____ _____

Date **Time**

_____

I have informed the patient about the procedure and the potential risks, benefits, alternatives and risk of those alternatives.

_____ _____

Physician Signature **Date**

Vein and Vascular Experts is a doctor's office regulated pursuant to the rules of the Board of Medicine as set forth in Rule 64B8,F.A.C.