CSA Surgical Center
Consent to Surgery and Other Procedures

Patient's Name: ____

I.PERMISSION: I authorize Dr. ____ and his/her surgical partners and assistants, permission to perform the following operation(s) or procedure(s):

____

____
(Fill in the operation(s) or procedure(s) without abbreviations before a signature is requested.)

The nature and the purpose of this operation or procedure has been explained to me. I have been told of the expected results; risks and benefits involved; other methods of treatment; the risks and benefits of not having surgery; and possible complications that may result from operation, procedure or the sedative or anesthetic I receive. I understand that during the procedure, the doctor may find that another or more extensive procedure is needed. I authorize and request the above-named doctor and his/her assistants to perform such procedure(s), including anesthetics and blood or blood products that are needed.

II. ANESTHESIA/SEDATION: I consent to and request the use of any anesthetics or sedatives, or the use of specific procedures that the anesthesiologist, anesthetist or surgeon feel are needed to perform the above operation(s) or procedure(s)

III.MEDICAL RADATION: I consent to the use of radiation (x-rays) which may be necessary for guidance and to obtain images for this procedure. I understand that, while all attempts will be made to minimize the amount of radiation I receive; there is always some degree of risk associated with radiation exposure.

III. TISSUE: I consent to the disposal by the hospital, under the direction of the doctor, of any bones, organs, tissues, fluids, foreign bodies, body parts or devices which it may be necessary to remove.

IV. OBSERVERS/PICTURES: I consent to observers in the room if the doctor approves them. I also consent to the taking and use of pictures or videos for medical education if this is approved by the doctor. I understand that my (the patient's) identity will not be revealed by the pictures or by written information attached to the picture.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM AND THAT I RECEIVED THE ABOVE EXPLANATIONS AS STATED. ALL BLANK SPACES ON THIS FORM WERE EITHER FILLED IN OR CROSSED OUT BY ME PRIOR TO SIGNING. I HAVE BEEN ABLE TO ASK THE DOCTOR QUESTIONS ABOUT CONCERNS I HAVE AND I HAVE HAD MY QUESTIONS ANSWERED.

______________________________	______________	______________
Signature of person authorized to give consent	Date	Time
______________________________		
Relationship to Patient If Not Self		
______________________________	______________	______________
Physician Signature	Date	Time
______________________________	______________	______________
Staff Witness Signature	Date	Time

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