GulfView Medical Institute PL
A new approach to health.

INFORMED CONSENT FOR SURGERY

Patient _____ Date _____/_____/_____ Time _____

I am scheduled for outpatient surgery on _____/_____/_____(Date) with Dr. Ravid.

I am scheduled to have: _____

I have been informed, and I understand to my satisfaction, the above mentioned procedure(s), why it is necessary, the risks to my health if the condition remains untreated and what the procedure will entail. I herein give my permission for the procedure above and administration of pre-surgery medication and local anesthesia for outpatient surgery. _____ **(Please Initial)**

The advantages and disadvantages of outpatient surgery have been explained to me as well as the procedure which will be performed on me. I also understand that during the course of the operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) or different procedure(s) than those planned. I authorize the above named surgeon or his designee(s) to perform such surgical procedures as are necessary and desirable in the exercise of professional judgment. _____ **(Please Initial)**

I have been made aware that there are certain risks inherent to the performing of any surgical procedure such as: loss of blood, infection, hematoma, pain, tingling, numbness or other nerve sensations including nerve damage, reactions to anesthesia and the formation of thick or otherwise objectionable scars. Additionally, I acknowledge that the doctor has made no promises to me, oral or written, in connection with the operation. I recognize that every surgical procedure involves uncertainty and that no result can ever be guaranteed. _____ **(Please Initial)**

Following surgery, I (will / will not) have a responsible adult drive me home as per previous arrangements. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthesia, and I will avoid making decisions, taking part in activities which depend upon full concentration or judgment during that period. _____ **(Please Initial)**

I release the doctor from any responsibility which takes place as a natural complication of the procedure. I also realize it is my responsibility to keep postoperative appointments. If I feel any problems exist such as bleeding, infection or if I have any doubts, I am to contact the doctor as soon as possible. _____ **(Please Initial)**

For the purpose of advancing medical education, I consent to photographing and/or recording of the operation provided my identity is not revealed by the pictures or descriptive text accompanying them.
_____ **(Please Initial)**

I consent to the disposal of any tissue which is removed in accordance with accustomed practice and procedure. I give my permission to have any tissue removed during the procedure sent for histologic examination to a pathologist. _____ **(Please Initial)**

_____ _____/_____/_____
Patient or Guardian Signature / Relationship Date

_____ _____/_____/_____
Physician Signature Date