CONSENT FOR SURGERY / OPERATION / PROCEDURE(S)

1. I authorize the performance of the following operation / surgical procedure(s)

   to be performed upon____

   by or under the direction of Drs.____

2. I UNDERSTAND THAT THE PHYSICIANS, ANESTHESIOLOGISTS, DENTISTS AND / OR PODIATRISTS WHO PARTICIPATE IN THE OPERATIONS OR PROCEDURE ARE **INDEPENDENT CONTRACTORS AND ARE NOT EMPLOYEES OR AGENTS MIDWEST CENTER FOR DAY SURGERY**, AS FULLY SET FORTH IN THE "ACKNOWLEDGEMENT OF UNDERSTANDING OF SERVICES PROVIDED BY INDEPENDENT CONTRACTORS" PROVIDED TO AND EXECUTED BY ME OR MY REPRESENTATIVE. ___________________
   Patient's Initials

3. My physician(s) has fully explained to me the condition requiring treatment and the nature, purpose, risk and benefits of the operation(s) / procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications. I was given the opportunity to ask questions and any such questions were answered to my satisfaction. No guarantee or assurance has been given by anyone as to the results that may be obtained. I am aware that the practice of medicine and surgery is not an exact science.

4. My consent is given with the understanding that any operation or procedure, including anesthesia, involves risks and hazards. The more common risks include; but are not limited to: infection, bleeding requiring blood transfusion(s), nerve injury, blood clots, heart attack, stroke, allergic reaction(s), damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.

5. Surgical operations and special diagnostic or therapeutic procedures all involve RISKS OF COMPLICATIONS, SERIOUS INJURY, OR DEATH, from both known and unknown causes. Therefore, except in cases of emergency or exceptional circumstances, these operations and procedures will not be performed unless I have had an opportunity to discuss them with my physician. I have the right to consent to or refuse a proposed operation or special procedure.

6. I consent to the performance of operations or other procedures in addition to or different from those now contemplated whether or not arising from presently unforeseen conditions, including the implantation of medical devices, which the above named physician(s) or his/her associate(s) or assistant(s) may consider necessary or advisable in the course of the operation.

7. I understand the risks, benefits, and alternatives to the type and method of anesthesia or sedation recommended, and I consent to the administration of such anesthesia as may be considered necessary or advisable by the physician(s) for this surgery / procedure, with the exception of _________________________________anesthesia.

8. I understand this surgery center is owned by physician/surgeon investors who also perform procedures at the surgery center, and that I may ask my physician/surgeon or the center administrator for further details.

9. I have been referred for my surgery / procedure to this surgery center by my surgeon.

10. I consent to the photographing or videotaping of the surgery or procedure(s) to be performed, including appropriate portions of my body for medical, scientific, or educational purposes, provided that my identity is not revealed by the pictures or by descriptive texts accompanying them.

11. I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my surgeon(s).

12. I consent to the disposal of any human tissue or body part which may be removed during the surgery / procedure(s).

13. If complications arise, I agree to be admitted to the hospital of my surgeon's choice.

14. I have been advised that there is a possibility of damage to teeth during surgery and administration of anesthesia, particularly if the teeth are weak, loose, decayed or artificial, and I waive any claim for damage to teeth as a result thereof.

15. I understand that, unless instructed otherwise, I am required to have a responsible adult accompany me after my surgery / procedure(s) and that I will be released to that person's custody, and must rely upon him/her for my return home and supervision, as instructed.

16. I release the surgery center from any responsibility for loss of and/or damage to money, jewelry, or other valuables I have brought to the surgery center.

17. I understand that if I am pregnant, or if there is the possibility that I may be pregnant, I must inform the surgery center immediately since the scheduled surgery / procedure(s) could cause harm to my (unborn) child or myself.

18. If I am not the patient, I represent that I have the authority of the patient whom, because of age or other legal disability, is unable to consent to the matters above. I represent that (a) I have the full right to consent to the matters above; (b) I agree to release, indemnify, and hold harmless the surgery center, its employees, agents, medical staff, partners, and affiliates from any liability or cost arising out of my lack of adequate authority to provide the consent set forth herein.

19. I understand that 77 Illinois Administrative Code, Chapter 1, Section 697.120, permits the surgery center to perform a blood test for HIV (the AIDS virus) on any patient during whose treatment a health care professional sustains a puncture, mucous membrane or open wound exposure to a patient's blood or other bodily fluids. A test for Hepatitis B and C may also be drawn.

20. I have not had anything to eat or drink since _________________________.

21. Advance Directives – Living Will – Health Care Proxy

    I understand that Advance Directives and Living Wills are NOT honored at the surgery center, and in the event of an emergency or life threatening situation, advanced cardiac life support will be initiated in every instance and patients will be transported to a facility providing a higher level of care.
    [ ] I have provided the surgery center with my Advance Directive/Living Will/Health Care Proxy.
    [ ] I do not have an Advance Directive/Living Will/Health Care Proxy.
    [ ] I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.
    [ ] I wish to have information on how I can obtain Advance Directive/Living Will/Health Health Care Proxy

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGMENT THAT:

1. I have read, understand and agree to the foregoing;
2. The proposed surgery / procedure(s) have been satisfactorily explained to me and that I have all of the information that I desire;
3. I hereby give my authorization and consent, and;
4. All blank spaces on this document have either been completed or crossed off if they do not apply prior to my signing.

______________________________	______________________________	______________________
SIGNED	**RELATIONSHIP TO PATIENT**	**DATE & TIME**

______________________________	______________________________
WITNESS	**DATE / TIME**

SURGEON'S ATTESTATION: Prior to the procedure, I discussed the condition requiring treatment and the nature, purpose, risks, and benefits of the operation(s), surgery/procedure(s), possible alternative methods of treatment, including non-treatment, and the possibility of complications with my patient or the patient's authorized representatives. I provided my patient or his/her representative with the opportunity to ask questions and answered all questions to their apparent satisfaction. I have reviewed the surgical consent form and verified that the planned surgery/procedure is accurate.
Surgeon's initials:______________

TRANSLATOR'S STATEMENT: I have verbally translated this consent into (applicable language)______________________for the benefit of the patient or his/her authorized representative who understands said language better than English. To the best of my ability, I believe the patient or his/her representative understands these statements, as witnessed by their signature on the consent form.
Translator's initials:_____________