

AUTHORIZATION AND CONSENT FOR SURGERY

1. Your doctor, _____ has recommended the operation or procedures listed below. He will perform the operation (or procedures) together with associates and assistants, including anesthesiologist, pathologists, and radiologist, to whom he may designate responsibilities. He may ask another surgeon, a surgical resident, or a surgical technician to assist.
2. The nature and purpose of your operation (or procedure) have been explained to you, as have the risks and consequences of the procedure, the risks and consequences of non-treatment, the probability of success, and any feasible alternatives. All operations (and procedures) involve the risks of unsuccessful results, complications, injury, or even death, from both known and unknown causes, and no warranty of guarantee is made as to result of cure. An alternate option and a second opinion were discussed with you by your surgeon.
3. If you need anesthesia, here are additional risks including, but not limited to, sore throat, lip injury, damaged teeth, Heart attack, pneumonia, stroke, nerve damage, intraoperative awareness and death. Your judgment and function may be impaired for up to 24 hours after receiving anesthesia and you should avoid driving or operating machines. Drinking alcohol, signing legal documents, or taking responsibility for another person. You must also have a responsible adult take you home after surgery.
4. You have the right to be thoroughly informed about your operation (or procedures) and to have your questions Answered prior to giving authorization or consent. This form is not a substitute for explanations from your doctor. You have the right to consent to or refuse any proposed operation (or procedure) any time prior to its performance.
5. Upon your authorization and consent, the operation (or procedure) previously explained will be performed. Additional or different procedures will be done only if your doctor thinks they are necessary because of unforeseen circumstances or an emergency.
6. By signing this form, you authorized your doctor to use his discretion in disposition of any member, organ, or tissue Removed during your operation. You further authorized your doctor to take photographs, or permit other persons to take photographs, and to use the negatives or prints as he deems necessary.
7. As your doctor will be focused solely on performing your surgery, he may arrange for other persons to attend your Operation (or procedures) for the purpose of administering anesthesia, or performing other specialized professional services, such as radiology, pathology, or product representatives. These individual are not agents, servants, or employees.
8. Your signature below constitutes your acknowledgment that (1) you have read and agree to the foregoing. (2) the operation (or procedure) listed below has been adequately explained to you by your doctor, and that you have received all of the information you desire concerning this operation (or procedure); (3) you have been provided with information about blood transfusion and options available to you; (4) you authorize and consent to the performance of the operation (or procedure); (5) you authorize the administration of medications or anesthesia as indicated.

I HAVE NOT EATEN OR DRANK SINCE MIDNIGHT _____.

I HAVE A RESPONSIBLE ADULT TO DRIVE ME HOME AND STAY WITH ME UNTIL TOMORROW MORNING _____.

Operation or Procedure:

I HAVE EXPLAINED IN DETAIL THE RISKS AND BENEFITS OF THIS PROCEDURE TO ENABLE THE PATIENT TO MAKE AN INFORMED CONSENT.

Physician: _____ Date ____ / ____ / ____

Patient: _____ Date ____ / ____ / ____

Witness: _____ Date Time: _____

BAY AREA SURGICAL GROUP
2222 Lafayette Street, Suite 101
Santa Clara, CA 95050

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____