CREEKSIDE SURGERY CENTER
Physician's Surgery Informed Consent

Patient's Name:_____ DOB:_____

_____ 1. I consent to the performance of the following operation/procedure: (technical name)
initials

_____

_____

_____

The purpose of this operation/procedure is: (lay language)

_____

_____

_____ 2. The nature and purpose of the operation/procedure, the benefits and risks of the operation/procedure
initials possibilities of complications, and the alternatives to this operation/procedure and their risks and benefits, have been explained to me.

_____ 3. It has been explained to me that a satisfactory result is expected, but that the following are some of the
initials complications or effects that could or may occur; bleeding, infection, damage to adjacent tissues or organs, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence, additional operations and in rare instances, paralysis or death; other:

_____

_____

_____ 4. No guarantee or assurance has been given by anyone about the results that may be obtained.
initials

_____ 5. I consent to the doctors performing whatever different or additional operations or procedures they deem
initials necessary or advisable during the course of the operation/procedure.

_____ 6. I consent to the administration of such anesthetics as may be considered necessary or advisable for this
initials operation/procedure.

_____ 7. I consent to transfusion of blood and/or blood products as needed and directed by my surgeon and/or
initials anesthesiologist. This may be my own blood that I have donated.

_____ 8. I was encouraged to ask any question I may have. All of my questions have been answered to my
initials satisfaction.

I have read and understand the content of this form.

_____
Patient's/Representative Signature Date

_____
Witness

_____
Physician's Signature

Patient Sticker
1/18/2012