ROSWELL SURGERY CENTER

CONSENT TO OPERATION OR OTHER PROCEDURE

1. I hereby authorize _____ and/or such assistants as may be selected by him/her to perform the following procedure(s): _____

_____

_____

_____

_____

_____

2. The procedure(s) listed above have been explained to me by my doctor, and I fully understand the risks and benefits of the procedure(s).

3. I recognize that during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set for the above. I further authorize and request that the above-named surgeon, his/her assistants or designees perform such procedures as are in his/her professional judgment necessary and desirable, including but not limited to, procedures involving pathology and radiology. The authority granted under this consent shall extend to procedures necessary to treat and correct conditions not known to the above doctor at the time the operation is commenced.

4. I am aware the Center does not honor Advance Directives.

5. I consent to the taking of photographs prior to, during or after surgery for medical documentation.

6. I consent to authorized observers in the operating room with the approval of my surgeon.

7. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.

8. **I have had nothing to eat or drink (no food or water) since 11:00 PM (__) or for the past (__) hours and I understand that food or liquids in my stomach will jeopardize my life while under anesthesia. _____initials**

9. **CONSENT TO HAVE BLOOD DRAWN:** I do hereby consent to the withdrawal of a blood sample. I understand that my blood withdrawal will be done only if an employee or physician of Roswell Surgery Center has had an accidental needle stick or mucous membrane exposure to my blood or body fluid. I further understand that the testing will be done in a manner that protects my privacy and is at no cost to me. Tests performed will include, but are not limited to: HIV (Aids) and HEP B (Hepatitis) antibodies.

10. I acknowledge that my physician may have an ownership interest in Roswell Surgery Center. I also acknowledge that I have the right to choose the provider of my healthcare services and have chosen Roswell Surgery Center.

11. I have been instructed to keep my valuables at home. I acknowledge that Roswell Surgery Center is not responsible for missing valuables.

Patient Name: _____

Signature of patient: _____ Witness: _____

Date:_____ Time:_____

(If other than patient, relationship to patient): _____