MANHATTAN SURGERY CENTER

MR #

Consent for Surgery

Case ID # DOS

Patient Name	DOB	Age	Sex	Surgeon

1. Pre-Operative Diagnosis:
2. Proposed Procedure or Operations:
3. I authorize the performance upon _____ under the direction of _____ and Manhattan Surgery Center to provide treatment and perform the procedure(s) listed above which may include administration of local or topical anesthesia.
4. I further authorize other duly licensed physicians with privileges at this surgery center to perform important tasks related to the above listed procedure(s).
5. I authorized qualified medical practitioners who are not physicians to perform certain important parts of the above-listed surgery or to administer the anesthesia. Such practitioners may perform tasks, including those specified below, if they are permitted to do so under the laws of this state. All tasks performed by such practitioners will be those within the practitioner's scope of practice, for which they have been granted privileges by this surgery center and will be performed at the direction of the surgeon performing the procedure.

   Practitioner Title: PHYSICIAN ASSISTANT — 1) Fulgurate simple lesions 2) Harvest vein grafts 3) Prepare bone/tendon/ligament grafts 4) Apply/adjust external fixation devices 5) Assist in placement/removal of metal fixation 6) Drill bone under guidance of surgeon.
6. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide physician care.
7. The operation(s) and/or procedure(s) listed to be performed, the advantages and disadvantages, risks and possible complications, and the anesthesia risks, benefits, as well as the alternatives, and the risks, benefits and alternatives associated with performing the procedure in the ambulatory surgical facility instead of a hospital have been explained to me by my physician. The doctor has satisfactorily answered all my questions.
8. I understand that all operations/procedures involve risks and possible complications. My doctor has discussed these with me. I understand there is always the unlikely possibility of a drug allergic reaction, bleeding infection, nerve injury, worsened pain, numbness, headache, spinal fluid leak, pneumothorax and paralysis. These are uncommon but some of these complications may require major surgery. There is a very small risk of stroke, cardiac arrest and death. I further understand no guarantees have been made.
9. I authorized and direct my physician to arrange for such additional services for me as deemed necessary or advisable, including but not limited to, the administration and maintenance of anesthesia and the performance of pathology and radiology services, to which I hereby consent.
10. I authorize the pathologist or physician to use their discretion in disposing of any member, organ, implant, prosthetic or other tissue removed from my person during the operation or procedure.
11. In the event of accidental exposure of my blood or body fluids to a physician, contractor or employee of the facility, I consent for testing of HIV and Hepatitis.

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12. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home following my operation/procedure. I acknowledge that I have been advised by the facility personnel not to drive until the day after my surgery/procedure as directed by my physician.
13. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use.
14. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual operation/procedure.
15. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought to the facility.
16. I understand that if I am pregnant or there is a possibility that I may be pregnant, I must inform the facility personnel immediately.
17. I understand that my physician may have an ownership interest in the facility and I acknowledge that I have the right to have the operation/procedure performed elsewhere.
18. I understand that in the rare event that hospitalization is required during or immediately after my operation/ procedure, my physician will arrange for coordination of care and my transfer to a local hospital. I consent to transfer to Roosevelt Hospital.
19. My signature below constitutes acknowledgement that (1) I have read or have had read to me that foregoing and I agree to it; (2) the operation(s)/procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the operation(s)/procedure(s) and any additional operation(s)/ procedure(s) deemed advisable by my physician in his/her professional judgment; (4) I authorize and consent to the administration of anesthesia for said operation(s)/procedure(s), as applicable.
20. If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent to the matters above. I have full right to consent to the matters above and I consent to same; I hereby indemnify and hold harmless this facility, its employees, agents, medical staff, partners and affiliates from cost or liability arising out of my lack of adequate authority to give consent.

Date Time Patient Signature or Person Authorized to Consent

Relationship

Date Time Witness Signature

I have explained to the above named patient the nature, purpose and comparative risks, benefits and alternatives associated with the procedure(s) named above and the comparative risks, benefits and alternatives associated with performing the procedure(s) in Manhattan Surgery Center instead of a hospital. The patient signed this form in my presence, following our discussion.

Physician Signature Date: Time:

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