SOUTH ATLANTA
VASCULAR INSTITUTE

# Surgical Consent

**Do not sign this form without reading and understanding its contents**

Patient Name: _____ Date of Birth: _____ /_____ /_____

I understand and acknowledge that the following procedure which has been described to me is to be performed on the patient:

_____

_____

_____

_____

and that as a result of the performance of the procedure, there is a material risk that the patient may suffer ALLERGIC REACTION, INFECTION, SEVERE BLOOD LOSS, LOSS OF OR LOSS OF FUNCTION TO ANY LIMB OR ORGAN, PARALYSIS OR PARTIAL PARALYSIS, DISFIGURING SCAR, BRAIN DAMAGE, CARDIAC ARREST, OR DEATH. I understand that in addition to these risks, there may be other risks associated with the procedure which have been discussed with my physician.

I understand and acknowledge that during the procedure described above, a condition may develop that may reasonably necessitate an extension of the original procedure or the performance of the procedure which are not known to be needed at the time this consent is obtained. I therefore consent to authorize the physician performing the procedure and associated healthcare providers to make decisions concerning the performance of and perform such procedure as they may deem reasonably necessary in the exercise of their professional judgement including such procedures that may be not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions that may arise during the procedure including conditions unknown or unforeseen at the time this consent is obtained.

Women of child bearing capability consent that they understand that surgery and anesthetic agents carry inherent risks in pregnancy to both the fetus and to the mother and this consent is signed with full awareness of the consequences.

I acknowledge and understand that by granting my consent, I have been informed in general terms of the following: a diagnosis of the condition requiring the procedure, the nature and purpose of the procedure, the material risks of the procedure, the likelihood of the success of the procedure, the

alternatives to the procedure and the prognosis if the procedure is rejected and that such was provided through conversation with the responsible physician, other medical personnel including nurses, physician's assistants, nurse practitioners, patient educators or through the use of pamphlets, booklets, video or audio tapes or their digital equivalent.

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 concerning the results of the procedure.

I acknowledge and understand that this Surgical Consent shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the responsible physician, and for all other medical personnel otherwise involved in the course of treatment.

I authorize retention, preservation or disposal of any tissue, specimen, organs, limbs or any other biologic tissue removed from my body during the authorized procedure.

I consent to allow the presence of observers and/or technical advisors during the procedure and to the photographing, recording or televising of the procedure as approved by my physician.

I consent to allow all licensing, accrediting and/or regulatory agencies access to my medical records as appropriate.

By signing below, I acknowledge I have read or explained to me and I understand this form and I voluntarily request and consent to all the physician or any physician designated or selected by him/her and all medical personnel under the direct supervision and control of such physician and all personnel which may otherwise be involved in preforming such procedures to preform the procedure described or otherwise referred to herein. I have been given ample opportunity to ask questions and any questions I have been asked have been answered or explained in a satisfactory manner.

Time: _____ Date: _____ Patient Signature: _____

Reason patient is unable to sign: _____

Time: _____ Date: _____ Witness Signature: _____

Time: _____ Date: _____ Physician Signature: _____