PORT JEFFERSON SURGERY CENTER, LLC
1500 Route-112 Building 3, Port Jefferson Station, NY 11776
Hours of Operation: 7am-5pm, Monday-Friday
Phone (Main): (631) 828-5555
Pre-Registration/Reception: (631) 828-5555 ext. 301 and ext. 302
www.portjeffsc.com

CONSENT AND REQUEST FOR SURGERY/PROCEDURE

Operation or Procedure: I, _____ (patient or authorized representative), authorize Dr. _____and First Assistant _____ to perform operation/procedure:
_____
_____
for a diagnosis of: _____
Alternatives: _____
Consequences of no treatment include, but are not limited to: _____

Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, and pneumonia. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include, but are not limited to:
_____
_____
_____

Benefits: _____

Pregnancy: I understand that medications and anesthesia given to me during my surgery may cause damage to an unborn child. If there is any chance I may be pregnant, I understand I need to notify my surgeon and anesthesiologist immediately. As a woman of childbearing age, I also consent to a pregnancy test being performed prior to my procedure. *I may refuse the pregnancy test by initialing at the end of this paragraph.* By doing so, I understand I also assume all risk for any damage related to this surgery or anesthesia that may occur to any unborn child I may be carrying. _____.

Additional Procedures: If my physician discovers a different, unsuspected condition at the time of surgery that may prove to be life-threatening if not taken care of immediately, I authorize him/her to perform such treatments as deemed necessary.

TISSUE: Any tissue, foreign body or prosthesis surgically removed may be retained for examination and disposed of by Boulder Surgery Center in accordance with accustomed practice and as required by regulation.

Cross out and initial all paragraphs to which you do NOT consent:

- I consent to visiting medical personnel observing my procedure at the discretion of my surgeon.
- I consent to visiting company representatives being present during my surgery for the sole purpose of consulting on the use of equipment/instruments.
- I consent to photographs or video taping of my procedure which may be done at the request of my physician.

I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the conditions. My physician has also discussed with me the probability of success of this procedure as well as the probability of serious side effects. **Recuperative Period**: My physician has discussed with me the probable length of the recuperative period and problems I may encounter during my recovery.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM

If you have questions as to the risks or hazards of the proposed surgery or treatment, or if any questions concerning the proposed surgery or treatment, ask your surgeon now BEFORE SIGNING THE CONSENT FORM. You have the right to withdraw consent for this procedure at any time before it is performed.

PATIENT'S CONSENT: I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. By my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Patient or Authorized Representative_____ Witness_____

Date_____ Time_____ Relationship (if other than Patient)_____

PHYSICIAN'S AFFIRMATION: I have explained the procedure indicated above and its attendant risks and consequences to the patient who had indicated understanding thereof and has consented to its performance.

Physician_____ Date_____ Time_____