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Consent for Procedure

Provider Location: [ ] Caswell Family Medical Center, Yanceyville [ ] James Austin Health Center, Eden

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider: \_\_\_\_\_

I hereby request that my provider perform the following operation/procedure on me:

- [ ]
[ ]
[ ]
[ ] Other \_\_\_\_\_

The provider has explained this procedure to me, and I completely understand the procedure in so far as possible. The following points have been made clear regarding the risks, benefits, and alternatives to the planned procedure.

- 1. There may be scars as a result of this procedure. Every effort will be made to conceal or minimize them.
2. There may be swelling and discoloration (bruising) that may persist for several days.
3. There may be scattered areas of numbness that may persist for an indefinite period of time.
4. There is no guarantee regarding the amount of improvement or permanency of the result. The goal is improvement, not perfection. It takes 1-6 months for healing, but complete healing may take up to 1 year.
5. Fluid and blood may accumulate at the site and may require aspiration.
6. This procedure carries the usual potential risks of surgery including infection, bleeding, and problems with wound healing, allergic reactions, death, or blindness with eye procedures.

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 this operation. I recognize that, during the course of the procedure, unforeseen conditions may necessitate additional or different procedures than those discussed above. I further authorize and request that the surgeon perform such procedures as are, in his/her professional judgment, necessary and desirable, including, but not limited to, biopsies, mole removals, injections, etc. The consent granted shall extend to remedying conditions that are known to the above provider at the time the procedure began.

I consent to anesthesia with local by numbing by the provider. I will be monitored until the effects of the medication wear off and I will then be discharged. The risks, benefits, and alternatives to anesthesia have been discussed with me.

I also give my permission for permission for persons to observe my procedure for the purposes of education, supplying needed equipment, providing support to the provider, or for accreditation or regulatory inspections.

I agree to keep the provider informed of any changes in my health and contact information so that he or she can notify me of findings from the procedure. I agree to cooperate with this provider in my care after surgery until I am completely discharged.

I have thought about the procedure and had the opportunity to ask questions. I have read this consent form and fully understand the instructions. The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully discussed with me by my provider. I consent to the provider performing the planned procedure.

I have been given post procedure instructions and agree to abide by them. Failure to comply with these may increase the possibility of complications or interfere with healing and the expected results.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_
(if patient is a minor)

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time Out Called at: \_\_\_\_\_ by \_\_\_\_\_