Good Samaritan Medical Center
A STEWARD FAMILY HOSPITAL
Steward

CONSENT TO OPERATIVE PROCEDURES

1. I hereby authorize Dr. Vikas Merchia and associates and such assistants as he/she may designate to perform the following operation: excision of posterior fourchette area and surgical repair to remove diseases and painful tissue. _____
_____
2. I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state): **None** _____
_____
3. If any conditions are found at the time of operation that were not recognized before and which call for procedures in addition to those originally planned, I authorize the performance of such procedures.
4. The nature, extent and purpose of the operation, with its associated benefits, potential risks and expected outcomes, as well as the benefits and potential risks of alternative methods of treatment have been explained to me. I acknowledge that no guarantee has been made as to the results that may be obtained.
5. Anesthesia will be given by or under the direction of the Anesthesia Staff.
6. I consent to have the pathologist perform such examination of specimens as may be deemed proper in arriving at the diagnosis. The specimens may also be used to advance medical knowledge or may be discarded.
7. I consent to the televising, videotaping and/or photographing of the operation(s), procedure(s), or treatment(s) to be performed for medical scientific or educational purposes.
8. I consent to the presence of a clinical consultant/observer upon the request/permission of the surgeon.
9. The possible need for a transfusion of blood and/or blood components, the risks involved, (including but not limited to the risk of contracting Viral Hepatitis B, C, or HIV/AIDS, or a major life-threatening transfusion reaction or infection), the benefits, the potential complication, the available alternatives and the possible consequences of not receiving a transfusion have been clearly explained to me. I understand that such risks exist despite the fact that the blood has been tested carefully. Notwithstanding the foregoing, I hereby consent to a transfusion of blood and/or blood components as deemed necessary or advisable by my treating physician during the course of my preoperative, operative and postoperative stay.

   ❑ Patient Refuses ❑ Not Applicable
10. Surgeon's comments, if any: ***Major RISKS including, but not limited to: Bleeding (possibly requiring transfusion); Infection; Injury to surrounding structures (bowel, bladder, nerves, ureter, possibly requiring repair). Failure to obtain desired results. Possible need for further surgery. Possible vascular or respiratory complications, e.g.: blood clots, pneumonia. All surgeries with potential risk of death***.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THAT THE SURGEON, OR HIS/HER DESIGNEE HAS ANSWERED ALL OF MY QUESTIONS.

I CERTIFY THAT I HAVE CONVEYED THE RISKS AND BENEFITS OF THE PROCEDURE, AS DESCRIBED BY THE PHYSICIAN, TO THE BEST OF MY ABILITY.

_____	_____		_____	_____	
Signature of Surgeon/Designee	Date	Time	Signature of Translator	Date	Time
_____	_____		_____	_____	
Signature of Patient/Designee	Date	**Time**	Witness	Date	Time

If patient is unable to sign or is under 18 years of age, complete the following:
❑ Patient is a minor _____ years of age.
❑ Patient is unable to sign because: _____
I am _____ of patient, and hereby consent to the surgical procedure(s) on behalf of the patient:

_____
Signature and Address of Parent or Legal Guardian