MERCER COUNTY SURGERY CENTER

CONSENT FOR OPERATIVE, THERAPEUDIC, OR DIAGNOSTIC PROCEDURE

THERE MAY BE TERMS USED IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND. PLEASE ASK FOR AN EXPLANATION BEFORE SIGNING

SURGERY DATE: _____

1. I, _____, authorize Dr. (s) Simonian/Bhatia/Dhillon/Protano/Weinstein and/or such assistants selected by him/her to perform upon the patient, the following procedure(s): Sigmoidoscopy with biopsy, cautery, and polyp removal if needed.

2. Dr. (s) Simonian/Bhatia/Dhillon/Protano/Weinstein has explained to me, and I understand, the nature and purpose of the procedure(s) proposed. He/she has counseled me as to the benefits and most common risks of this procedure. He/she has also explained to me the possible discomforts I may experience. I have discussed with physician possible alternatives to this treatment, including no treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I understand the possible complications, which have discussed and those that are considered to be the most common, as well as other less common complications that may occur.

   Risks include, but are not limited to: bleeding, infection, perforation.

3. I acknowledge that no guarantees have been made or implied to me regarding the expected results of the operation or procedure. I understand that medicine is not an exact science and that additional operations or procedures may be found necessary during the course of the proposed procedure. I understand that during this procedure(s), unforeseen conditions may require additional or different procedures than those stated above in this consent. I, therefore, authorize and request my physician, his assistants, or his designees perform such procedures as are, in his professional judgment necessary and desirable. The authority granted under paragraph three shall extend to remedying conditions that are not known at the time the procedure is commenced.

4. I consent to the admission of professional observers (physicians, nurses, allied health professionals, students, and equipment vendors) to the operation or treatment room as approved by my physicians.

5. I consent to the photographing or videotaping of the procedure(s) to be performed for the documentation and/or medical educational purposes.

6. I understand that any organs or tissues surgically removed may be examined and may be retained by the facility for medical, scientific, or educational purposes, and such tissues or parts may be disposed of in accordance with accustomed practice.

7. My signature on this consent form confirms that I have read and fully understand was of the paragraphs above. All blank statements have been completed prior to my signing. I have crossed out and initialed any paragraphs to which I do not agree.

Patient/Relative of Guardian _____Witness _____
(SIGNATURE) (TO SIGNATURE ONLY)

Print Name _____ Print Name _____

Date _____ Time _____ (AM) (PM _____
(RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT)

Physician's Signature: _____ Date _____