Consent for Surgery, Medical Treatment, Anesthesia, or Other Procedure

Washington State law guarantees that you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the healthcare team, YOU must enter into the decision-making process. This form has been designed to ACKNOWLEDGE YOUR ACCEPTANCE OF TREATMENT RECOMMENDED by your physician.

Patient: _____ **Date of Birth:** _____ **Patient ID#:** _____

Scheduled at: Edmonds Center for Outpatient Surgery

1. I hereby authorize Dr. Steven Swedberg and/or such associates or assistants, including, if applicable, other physicians who will have an active process in the surgery, and other health care providers as may be selected by said physician to treat the following conditions(s), which has (have) been explained to me: condition(s): Visually Significant Cataract of Left Eye
2. The procedures planned for treatment of my condition(s) have been explained to me by my physician. I understand them to be:

   Cataract Extraction with Intraocular Len Implant of Left eye
3. a. I have been informed of certain risks and complications that can reasonably be anticipated with the procedure described in Paragraph 2. I have been informed that there are significant risks, which include but are not limited to injury to other vessels, severe loss of blood and transfusions, nerve injury, clots, thrombosis, infection, and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I acknowledge that no warranty or guarantee has been made to me as a result or cure.

   b. I have been informed that the reasonable alternative(s), if they exist, to this treatment have been discussed.
4. I recognize that, during the course of the operation, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore authorize my above-named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her, or their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.
5. I consent to the administration of anesthesia by my attending physician, by an anesthesiologist, or by other qualified party under the direction of a physician as may be deemed necessary. The anesthesiologist, or nurse anesthetist, is an independent contractor and not an employee or agent of Proliance Surgeons. I understand that the administration of anesthesia and anesthetics involves risks of complications; serious possible damage to vital organs, such as the brain, heart, lung, liver, and kidney; and nerve injuries, and that it may result in paralysis, cardiac arrest, brain damage, and/or brain death from both known and unknown causes.
6. Any tissues or parts surgically removed may be disposed of or utilized for educational or research purposes by the hospital or physician in accordance with accustomed practice.

FULL DISCLOSURE

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment; of the possible alternative forms of treatment; and any recognized serious possible risks, complications, and alternative forms of treatment, including nontreatment.

I certify I have had the opportunity to ask questions and have had all aspects of this medical treatment explained to my satisfaction and I consent to proceeding with the procedures(s) referenced in this document.

_____ PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE
Date: **Time:**

_____ RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON TO PATIENT

Witness: _____
Date: **Time:**

Physician: _____
Date: **Time:**