KLAMATH SURGERY CENTER
2640 Biehn ST Suite 2
Klamath Falls, OR 97601

PATIENT NAME: **Date:**
PROCEDURE:

1. I hereby authorize my surgeon and the assistants of his/her choice to perform upon me the above listed operation(s)

   And if any unforeseen condition arises in the course of the operation/procedure/procedure calling in his/her judgment for procedures in addition to or different from those now contemplated, I further request and authorize him and his assistants to do whatever he/she deems advisable. I am aware that I may have surgery performed at any other facility where my surgeon has privileges.

2. I hereby authorize **Klamath Surgery Center**, its medical and professional staffs, employees and agents to undertake the appropriate service and care necessary in conjunction with those procedures which I have authorized the above-named physician to undertake in his/her efforts to alleviate my said condition or conditions.

3. The nature, benefits and purpose of the operation/procedure, possible alternative methods of treatment (to include risks, benefits and complications of such alternatives), risks involved, my diagnosis and the possibility of complications have been explained to me. I have had an opportunity to discuss this operation/procedure with the doctor or doctors concerned, and I have received answers to all questions I asked, to include expected outcomes.

4. I have also been informed that in the performance of any surgical procedure there are other risks, including but not limited to severe loss of blood, infection, cardiac arrest, respiratory arrest, perforation, shock, blood clots in veins or lungs, unplanned injury, puncture, perforation or laceration to organs, nerves, blood vessels or tissues, skin breakdown as well as reaction to the administration of anesthesia, diagnostic agents, dyes, medications, and that these risks could cause permanent disability or death. The likelihood and severity of these risks have been explained to me. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of the operation/procedure or procedure.

5. I consent to the administration of medication, blood, or blood products, as deemed necessary by my physician(s). I understand that there are inherent risks in every blood transfusion and these risks have been explained to me.

6. I acknowledge that I have, to the best of my ability, informed my surgeon of all known allergies, unusual reactions to medications, radiopaque and radioactive media and anesthetic agents.

7. I consent to the administration of such anesthetics, as administered by my physician, to include local anesthetics, and as may be considered necessary or advisable by the physician responsible for this service, with the exception of _____
   (state "none", "spinal anesthesia", etc.)

   The risks, benefits and alternatives of the selected anesthesia have been disclosed to me.

8. The advantages and disadvantages of outpatient surgery have been explained to me. I realize that, following my operation/procedure, admission to a hospital might be advised. I agree to admission at **SkyLakes Medical Center** if, in the opinion of my physician, such admission should be deemed advisable in my best interest.

9. Following surgery, I will have a responsible adult drive me home as per previous arrangements. I realize that impairment of full mental alertness may persist for several hours following the administration of anesthesia and I will avoid making decisions, or taking part in activities which depend upon full concentration or judgment, during this period.

10. Written instructions and directions have been given to me, and I have read and will comply to all of them.

11. I consent to other medical services deemed necessary or advisable including but not limited to pathology and radiology services. I authorize **Klamath Surgery Center** to dispose of any specimen or tissue taken from my body or to retain specimen (tissues) for whatever reason they deem appropriate.

INFORMED CONSENT: OPERATION/PROCEDURE, ANESTHESIA OR OTHER PROCEDURES

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12. I consent to taking and publication of any photographs, motion picture or video tapes in the course of this operation/procedure for the purpose of advancing medical education, provided my identity is protected. I understand that this organization will retain the ownership rights to these images and that I will be allowed to view them or to obtain copies. I understand these images will be stored in a secure manner that will protect my privacy and that will be kept for the time period required by law. Images that identify me will only be released with my written consent.
13. I consent to the admittance of qualified observers, such as nursing/medical students, technicians or otherwise authorized persons in the Operating Room for the purpose of medical education, provided my confidentiality is protected. I also release the Facility and attending physician from any and all liability that may result from the observers' presence.
14. I am aware that during the course of this admission an Advance Directive "Living Will" will not be honored.
15. I hereby give my consent for certain qualified persons to review my medical record. Such persons would include but not be limited to state, federal and accreditation surveyors, risk management consultants, third party carriers, and quality improvement staff.
16. I acknowledge and agree that I have received information regarding ownership of the facility, information regarding surgical site infections, have been offered a copy of the Patients Rights and Responsibilities and Notice of Privacy, and have been given an opportunity to ask questions concerning these things.
17. I am aware that it may become necessary to test my blood for Hepatitis B and C and for HIV and do hereby consent for such tests. Furthermore, I am aware that should I test positive for certain conditions such as HIV, TB, Viral Meningitis or other diseases that are reportable to the health department and/or the Center for Disease Control that such information shall be disclosed to those entities.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR THIS OPERATION/PROCEDURE, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.

_____	_____	_____am/pm
Signature of Patient	Date	Time

_____	_____	_____am/pm	_____
Signature of Witness	Date	Time	Relationship of Witness to Patient

If patient is not able to sign for himself, the following is to be completed and appropriate signature obtained:

☐ Patient named above is a minor of _____ years of age.

☐ Patient named above is unable to sign because _____.

_____	_____	_____am/pm	_____
Signature of Substitute	Date	Time	Relationship of Substitute to Patient

INFORMED CONSENT: OPERATION/PROCEDURE, ANESTHESIA OR OTHER PROCEDURES