Patient Name__________________________________________

MR #______________________________________________________
or Patient Sticker Only

□ Laurel Surgical Center - Greensburg, PA 15601
□ Norwin Medical Commons - North Huntingdon, PA 15642

AMBULATORY SURGICAL CENTER CONSENT TO SURGERY
DIAGNOSTIC AND TREATMENT PROCEDURES

1. I have been told I have the following condition or presumptive diagnosis: ________________________________

2. I hereby request that Dr. ________________________, and such assistants as may be selected by him/her, perform the following procedure(s)/treatment(s): _____________________________
on ________________________________

(Name of Patient)

3. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. I have been informed of the following:
   • A description of the proposed procedure/treatment.
   • The indications for the proposed procedure/treatment.
   • The benefits related to the procedure/treatment.
   • The likelihood of achieving the procedure/treatment goals.
   • Treatment alternatives, and such alternatives’ material risks and benefits.
   • The probable consequences of declining the recommended or alternative procedure/treatment.
   • Who will provide the procedure/treatment.

I understand the information provided and give this consent voluntarily.

4. I HAVE BEEN ADVISED AND MADE AWARE OF THE RISK(S) AND COMPLICATION(S) THAT ARE ASSOCIATED WITH THE PROCEDURE(S)/TREATMENT(S) DESCRIBED ABOVE AS WELL AS THE ALTERNATIVE METHODS OF TREATMENT.

5. DISCLOSURE OF ALL RISKS, BENEFITS AND ALTERNATIVES ASSOCIATED WITH PERFORMING THE PROCEDURE IN AN AMBULATORY SURGICAL FACILITY INSTEAD OF A HOSPITAL HAVE BEEN EXPLAINED TO ME, INCLUDING THAT THERE ARE NO BLOOD PRODUCTS ON SITE AT THE FACILITY AND THAT THE FACILITY WILL HAVE TO UTILIZE EMS TO TRANSPORT ME TO AN ALTERNATE LOCATION IN THE EVENT THAT COMPLICATIONS WERE TO ARISE NECESSITATING A HIGHER LEVEL OF CARE.

6. I consent to the administration of anesthesia, including general anesthesia, and to the use of such anesthetics as are deemed advisable. In addition to the risks identified to me, I have also been advised of the potential risk of injury and/or damage to teeth.

7. If, during the course of the procedure(s), any unforeseen conditions arise which necessitate additional or different procedures, I further request and authorize the above-named physician or his/her designee to perform such procedure(s)/treatment(s), which in his/her professional judgment are necessary and desirable, including, but not limited to, procedures involving blood and blood products, pathology and radiology. The authority granted here shall extend to treating conditions that are not known at the time the procedure(s)/treatment(s) is/are commenced.

8. I authorize the administration of blood and blood products as may be considered necessary or advisable in connection with the above described procedure(s)/treatment(s) both during the procedure and for the remaining period of hospitalization. I have been informed of the potential benefits, risks or alternatives to receiving blood and blood products.

9. 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 RESULT OF THE PROCEDURE(S)/TREATMENT(S).

10. If a Do Not Resuscitate (DNR) order was in place prior to this procedure(s)/treatment(s), this DNR order will be suspended during the procedure and through the initial recovery phase of this procedure as determined by the attending surgeon/physician, unless documented otherwise in my medical record. The initial recovery phase of my procedure ends when I am either discharged from the recovery room/procedure location or (if my procedure is bedside) when my physician leaves my bedside after the procedure.

11. I hereby authorize Excela Health to dispose of the removed tissues, parts, or organs resulting from the procedure(s)/treatment(s) authorized above.

12. I consent to the admittance of clinical observers to the operating room and to the clinical photographing and televising of the procedure(s)/treatment(s) to be performed. All such pictures and films shall remain the exclusive property of Excela Health and shall be accorded the same level of confidentiality as my medical record.

13. BY MY SIGNATURE BELOW, I CERTIFY THAT I UNDERSTAND THE CONTENT AND MEANING OF THIS DOCUMENT AND I ACCEPT THE RISKS AND CONSENT TO THE PROCEDURE DESCRIBED ABOVE.

Witness ____________________________________________ Date/Time ________________

Printed Name__________________________________________

Patient’s Signature ____________________________ Date/Time ________________

(or Patient’s Legally Authorized representative if Patient lacks capacity)

I declare that I have personally explained the purpose of this procedure, its risks, complications, and benefits, and any alternative methods of treatment. I believe the patient (or his/her legal representative) understands the above.

Physician Signature ____________________________ Date/Time ________________

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