# JUPITER OUTPATIENT SURGERY CENTER, LLC

4/12

2055 N. Military Trail, Suite 100, Jupiter, FL 33458 (561) 741-1705

## PAIN MANAGEMENT

### CONSENT FOR SPECIAL PROCEDURE

IT IS IMPORTANT FOR YOU, THE PATIENT, TO READ THIS CONSENT FORM CAREFULLY

1. I hereby authorize Dr._____ and whomever he/she may designate as his/hers assistants, to perform upon_____
(name of patient or "myself")
the following procedure _____

_____
(procedure(s) to be performed)

If any unforeseen condition arises in the course of the procedure calling in his/hers judgment for procedures in addition to or different from those now contemplated, I further request and authorize him/her to do whatever he/she deems advisable.

2. The nature of my condition, the nature and purpose of the procedure, possible alternative methods of treatment, as well as the benefits to be reasonably expected have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.
3. I have discussed the likelihood of major risks or complications of this procedure including (if applicable) but not limited to bleeding, infection, nerve damage, seizure, muscle weakness, paralysis, secondary injury from falls, pneumothorax, headache, drug reaction, loss of sensation, loss of limb function, brain damage and death.
4. I consent to the administration of drugs, intravenous fluids or blood products that may be deemed necessary during the course of the procedure. The risks include, but are not limited to drug reaction, transfusion reaction, transmission of infectious diseases, lower breathing rate, lower blood pressure, brain damage and death.
5. I consent to the taking and publication of any photographs in the course of this procedure for the purpose of advancing medical education, provided my identity is protected.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT, THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE AND THAT ALL BLANKS OF STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN BEFORE I SIGNED.

**X**_____DATE:_____ TIME:_____
Signature of patient

**When patient is a minor, incompetent or unable to give consent:**

**X**_____DATE:_____ TIME:_____
Signature of person authorized to sign for patient

Relationship to patient _____ Witness_____
(to signature only)

***To Be Completed By Procedure Physician on Day of Procedure:***

I have explained the patient's condition, the need for treatment, the benefits of the procedure, and the risks involved; relevant treatment options and their risks; likely consequences if those risks occur; the significant risks and problem specific to the patient; and the likelihood of success for this procedure and patient. I have reassessed the patient with the following findings:

☐ No change from previous assessment ☐ Changes as documented on Progress Note

Procedural Physician's Signature:_____

Date:_____ Time:_____

Jupiter Outpatient Surgery Center, L.L.C.
2055 N. Military Trail #100 Jupiter, FL 33458

## INFORMATION AND CONSENT FOR ANESTHESIA SERVICES

In order to allow informed consent for Anesthesia Services, the following information is offered.

**IT IS IMPORTANT THAT YOU, THE PATIENT, READ THIS CONSENT FORM CAREFULLY:**

General anesthesia involves making the patient unconscious. This involves the use of such agents as Propofol, sedatives, narcotics, and inhalation agents such as nitrous oxide, oxygen, Desflurane, Sevoflurane, and Forane. Muscle relaxing agents may be used when required. An endotracheal tube is used frequently. This is a tube inserted into the windpipe to insure a proper airway. It is not possible to inform you of every agent to be used or dosage to be given because what is used is influenced by the reaction of the patient and the requirements of surgery. It is common to induce or begin general anesthesia by injecting Propofol into a vein, but this may also be done with other intravenous agents or by inhalation agents.

Complications of anesthesia are relatively uncommon, but can happen. It is important that you realize that there are risks involved undergoing any type of anesthesia, including, but not limited to, general, spinal, local, nerve block or intravenous regional anesthesia.

While it is impossible to advise you of every conceivable complication, some possible complications are as follows:

- Frequently, nausea and/or vomiting is not uncommon post procedure.
- Aspiration (inhaling vomitus into the lungs) and pneumonia
- Nerve injuries and possible weakness or paralysis, loss of sensation, loss of limb function, pain, headache, low blood pressure, seizure or loss of vision.
- Soreness of the throat and hoarseness are very common occurrences.
- Untoward reactions which can involve allergic type reaction or even cardiac arrest and death.
- Teeth can become loosened or broken, especially if caps or crowns are involved.
- Granulomas and polyps can form on the vocal chords.
- Blood transfusions may be required and, in this case, there is some risk of Hepatitis, AIDS, or other reactions. No test exist which can completely prevent every possibility of Hepatitis or AIDS.
- Occasionally, dreams can occur during or after general anesthesia
- Rarely, there may be recall events during procedure, and this cannot be completely eliminated or prevented. This is more common during general anesthesia for cesarean section and emergency surgery.
- A breathing machine may be required after surgery.
- Medical complications can occur which involve the heart, lungs, and circulatory system such as stroke, organ damage, blood clots, abnormal heart rhythms, phlebitis, heart attack, infection, excessive bleeding, drug reactions and death.

In the ambulatory care setting, if a patient should suffer a cardiac or respiratory arrest or other life threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with State law, the facility is notifying you it will not honor previously signed Advance Directives for any patients. If you disagree, you must address this issue with your physician prior to signing this form.

In order to minimize the possibility of aspiration, the patient is required not to eat or drink anything for a period of time before surgery. In elective cases, this is usually from midnight prior to surgery. It is extremely important not to eat or drink anything during this time, because aspiration of undigested food or significant amounts of stomach contents can lead to severe pneumonia, respiratory failure and death.

The undersigned physician has fully explained the nature and expected benefits, alternatives and risks involved in the procedure.

I HEREBY CERTIFY THAT I HAVE READ THIS FORM (OR HAVE HAD IT READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT. I DO NOT DESIRE ANY FURTHER EXPLANATION. I HEREBY CONSENT TO THE ADMINISTRATION OF ANESTHETICS AS MAY BE CONSIDERED NECESSARY OR ADVISABLE. I AUTHORIZE ADMINISTRATION OF BLOOD TRANSFUSIONS OR BLOOD COMPONENTS IF SUCH IS DEEMED ADVISABLE.

_____ _____

Signature of Patient (Parent/Guardian Where Applicable) Physician

_____ _____

Witness Date Time AM/PM