GULF COAST ENDOSCOPY CENTER
CONSENT FOR SURGICAL PROCEDURES

Patient Name: _____

Right	Left	Both	
❑	❑	❑	**CATARACT EXTRACTION WITH PHACOEMULSIFICATION:** Lens removed by liquidfication with insertion of lens implant.
❑	❑	❑	**LIMBAL RELAXING INCISION (LRI):** Incision made to reduce astigmatism on the surface of the cornea
❑	❑	❑	**BLEPHAROPLASTY:** Removal of excess skin from eyelids.
❑	❑	❑	**Other Surgery:** _____

I understand the above indicated procedure, the nature, purpose and possible complications and medical services described, as well as the risks and benefits reasonably expected and the alternative methods of treatment. My Physician_____, has explained to me the general method of the procedure to be performed under Monitored Anesthesia Care (MAC), such as medication administered intravenously to relax me. In addition, photographs may be used for scientific, educational or research purposes and may be taken during the procedure. I understand my identity would be protected.

A. The Physician has also explained to me the potential complications of the procedure and anesthesia, such as, but not limited to, adverse drug reactions, bleeding, phlebitis, hemorrhaging, infection, pain, vision loss, vitrectomy (leaking of vitreous jelly from eye), chronic irritation, retinal detachment, the need for wound revision, removal of retained lens material or lens exchange, loss of visual acuity, possible stroke, heart attack, pneumonia, perforation and even death. Additionally, the physician has explained to me that the procedure/ procedures ia/are not considered infallible, which may result in the possibility of blindness or loss of an eye. NOTE: Not all potential complications apply to all procedures.
B. The Physician has explained to me the alternatives, one of which, is to refuse this procedure. I acknowledge that no guarantees or assurance has been made to any results or risks, and that I assume such risks.
C. In the event the Physician/Staff is exposed to my blood, body fluids, or contaminated materials, I agree to allow testing that will determine the presence of HIV and/or Hepatitis. An accredited laboratory will perform the test(s) at no cost to me.
D. I hereby request , consent, and authorize Gulf Coast Endoscopy Center, my Physician(s)/Assistants to perform the procedure indicated above. I further authorize and request that, should any unforeseen condition/ complication arise during the procedure, Physician(s) and assistants take whatever action necessary and perform whatever procedure they deem advisable. This may include transferring me to a local acute care hospital. The Center, at that time, will no longer be held responsible for my personal belongings.
E. I further authorize my Physician and the Gulf Coast Endoscopy Center to dispose of any tissue surgically removed in accordance with accustomed practice.

I have read (or this or this has been read to me), I understand, and agree with the above. I confirm the risks, benefits and alternatives have been explained to my satisfaction.

_____

Patients signature or person authorized to sign — Date/Time

_____

Witness — Physician Signature (I have discussed procedures with patient)

PT. IDENTIFICATION