

Surgery on Sunday, Inc.

Helping Those In Need

INFORMED CONSENT FORM

Proposed Procedure _____

Surgeon _____

INFORMED CONSENT TO OPERATION AND OTHER MEDICAL SERVICES INCLUDING TRANSFUSION(S)

1. Surgery On Sunday, Inc. (SOS) maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operation and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of SOS, but independent contractors and therefore, are the patient's agents or servants. SOS provides volunteer physician, nursing and support services plus required facilities.
2. The procedure(s) listed to be performed and the advantages and disadvantages, risks and possible complications as well as the alternatives have been explained to me by my physician. The doctor has answered my questions.
3. My consent is given with the understanding that any operation or procedure involves risks and hazards. The more common risks include: infection, bleeding with the need for blood transfusion, nerve injury, blood clots, heart attack, stroke, allergic reaction, damage to teeth or bridgework, and pneumonia. These risks can be serious and possibly fatal.
4. I authorize and direct the above named to arrange for such additional services for me as he or she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia, and the performance of pathology and radiology services, to which I hereby consent.
5. I authorize the pathologist or physician to use his or her discretion in disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation(s) or procedure(s).
6. SOS may participate in residency and other training programs for physicians, allied health professionals and other providers of services. All rendered by individuals in training will be supervised and reviewed, as appropriate, by appropriate personnel, I hereby consent to care and treatment from individuals in training and to the review of my patient record by same.
7. **I DO / DO NOT** (circle one) authorize the administration of transfusions of whole blood or blood products to me as may be deemed advisable by the anesthesiologist, my attending physician and/or is associates or assistants. I understand that despite the exercise of due care the transfusion of blood or blood products is always attended with the possibility of some ill effects such as the transmission of hepatitis, HIV or certain other diseases, accidental immunization, or allergic reaction. I understand that in an emergency it may be necessary for the patient's well being to use existing stocks of blood which may not include the most compatible blood types. (If the patient circles **DO NOT**, obtain the patient/guardian signature on the Refusal to Permit Blood Transfusion form)
8. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or volunteer of SOS, I consent to testing for HIV and Hepatitis.
9. I understand it is my responsibility and I have arranged for a responsible adult to drive me home and remain with me following my surgery. I acknowledge that I have been advised by facility personnel not to drive until the effects of any medications have worn off. I understand this to mean that I should not drive until the day after my surgery/procedure or as directed by my physician.
10. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that his individual(s) will not participate in the actual procedure.
11. I consent to the use of video-taping or photography that may be used for scientific or teaching purposes, and to the review of my medical record for bona fide medical healthcare research providing my name or identity is not revealed.
12. I release SOS from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.
13. I understand that if I am pregnant or if there is any possibility I may be pregnant, I must inform SOS immediately since the schedule proceed could cause harm to my child or to myself.
14. I understand that in the rare event the hospitalization is required during or immediately after surgery, my physician will arrange for my transportation to a local hospital.
15. I have not eaten or taken fluids, not even water, since DATE _____ TIME _____ AM / PM except for a sip of water taken with medication as instructed by my physician.
16. My signature below constitutes my acknowledgement that (1) I have read or have had read to me the foregoing, and I agree to it; (2) the procedure(s) has been adequately explained by my physician; (3) I authorize and consent to the performance of the procedure(s) and any additional

procedure(s) deemed advisable by my physician I is or her professional judgment; (4) I authorize and consent to the administration of anesthesia the said procedure(s).

17. If I am not the patient, I represent that I have the authority of the patient who, because of age or other legal disability, is unable to consent to matters above. I have full right to consent to the matters above, and I consent to same; (b) I hereby indemnify and hold harmless SOS, its employees, the volunteers, agents, and affiliates from any cost or liability arising out of my lack of adequate authority to give this consent.

DATE _____ TIME _____ PATIENT'S SIGNATURE _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____

If patient is a minor or unable to sign complete the following: SIGNATURE _____

Patient is a Minor Patient is unable to sign because _____

DATE _____ TIME _____ SIGNATURE _____ RELATIONSHIP _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____

REQUEST FOR ADMINISTRATION OF ANESTHESIA

I understand that it will be necessary to be placed under anesthesia in order to perform the above described operation, and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesiologist, surgeon and nurse anesthetist. Anesthesia involves risks of the surgical procedure itself. These risks include but are not limited to, adverse drug reactions, brain damage, death, nerve injury, damage to teeth or dental work, damage to vocal cords, respiratory problems minor pain and discomfort, damage to arteries or veins, headaches, backache or worsening pre-existing disease(s). The purpose, necessity, and risk of anesthesia have been explained to my satisfaction by a physician and there has been sufficient opportunity to discuss the proposed treatment and associated risks.

I DECLARE AND REPRESENT THAT I HAVE READ AND UNDERSTAND IT IS TRUE. No guaranty or warranty has been made to the result of than esthetic procedures.

DATE _____ TIME _____ PATIENT/AUTHORIZED AUTHORITY _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____

ADVANCE DIRECTIVES/LIVING WILL/HEALTH CARE PROXY

I understand I have the right to make choices regarding life-sustaining treatment (including recitative-measures)

Yes, I have provided SOS with a copy of my Advance Directive/Living Will/HealthCare Proxy. The facility has explained to me their policy regarding the honoring of this document and I agree to proceed with the proposed procedure as schedule.

I do not have an Advance directive, Living Will/Health Care Proxy

I wish to have information on how I can obtain an Advance Directive/Living Will/Health Care Proxy

DATE _____ TIME _____ PATIENT/AUTHORIZED AUTHORITY _____

REFUSAL TO PERMIT BLOOD TRANSFUSION

I request that no blood or blood derivatives be administer to _____

During this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending physician or their assistants to preserve life, or promote recovery. I hereby release the hospital, its personnel, and the attending physician for many responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

DATE _____ TIME _____ PATIENT/AUTHORIZED AUTHORITY _____

DATE _____ TIME _____ WITNESS TO SIGNATURE _____