SURGERY Center OF LANCASTER

810 Plaza Blvd., Suite 101
Lancaster, PA 17601
Telephone: 717-431-2368
Fax: 717-431-2540

CONSENT TO OPERATION OR OTHER SPECIAL PROCEDURE

PATIENT NAME _____ PHYSICIAN: _____

PROCEDURE:_____

□ Atlanto-axial or atlanto-occipital joint injection □ Hip Joint Injection, □ Sacroiliac Joint Injection
□ Cervical, □ Thoracic, □ Lumbar medial branch and/or facet joint injection
□ Cervical, □ Thoracic, □ Lumbar medial branch radiofrequency neurotomy
□ Cervical, □ Thoracic, □ Lumbar Epidural Injection (Interlaminar or transforaminal approach)
□ Cervical, □ Thoracic, □ Lumbar Discography □ Coblation Nucleoplasty
□ Injection with Radiopaque Dye 72275 □ Injection with Fluoroguide with Dye 76005
□ Other_____

DIAGNOSIS: DEGENERATIVE DISC DISEASE DISPLACED DISC SPINAL STENOSIS RADICULITIS
POST LAMI SYND FACET/SPONDYLOSIS

OTHER:_____

1. The facility maintains personnel and facilities to assist physicians and surgeons as they perform various surgical operations and other diagnostic or therapeutic procedures. Generally, such physicians, surgeons and practitioners are not agents, servants or employees of the facility, but independent contractors and, therefore, are the patient's agents or servants. The facility provides nursing and support services and facilities; the facility does not provide physician care.
2. The operation(s) and/or procedure(s) listed to be performed, the advantages and disadvantages, risks and possible complications, and the anesthesia risks, benefits, as well as the alternatives, and the risks, benefits and alternatives associated with performing the procedure in the ambulatory surgical facility instead of a hospital have been explained to me by my physician. The doctor has satisfactorily answered all my questions.
3. I understand that all procedures involve risks and possible complications. My doctor has discussed these with me. I understand there is always the unlikely possibility of a drug or allergic reaction, bleeding, infection, nerve injury, worsened pain, recurrent pain, numbness, headache, spinal fluid leak, pneumothorax and paralysis. These are uncommon, but some of these complications may require major surgery. There is a very small risk of stroke, cardiac arrest and death. I further understand that no guarantees have been made.
4. I authorize and direct my physician to arrange for such additional services for me as deemed 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 their discretion in disposing of any member, organ, implant, prosthetic, or other tissue removed from my person during the operation or procedure.
6. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor or employee of the facility, I consent to testing for HIV and Hepatitis.
7. I understand that it is my responsibility and I have arranged for a responsible adult to drive me home 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 as directed by my physician.
8. I hereby consent to the presence of other person(s) for the sole purpose of observation and/or education. I understand that this individual(s) will not participate in the actual procedure.
9. I release the facility from any responsibility for loss and/or damage to money, jewelry or other valuables I brought into the facility.
10. I understand that if I am pregnant or there is a possibility I may be pregnant, I must inform the facility immediately.
11. I understand that my physician may have an ownership interest in the facility, and I acknowledge that I have the right to have the operation/procedure performed elsewhere.
12. I understand that in the rare event that hospitalization is required during or immediately after my surgery, my physician will arrange for my transfer to a local hospital.
13. 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 and any additional procedure(s) deemed advisable by my physician in his/her professional judgment; (4) I authorize and consent to the administration of anesthesia for said procedure(s).
14. 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 the matters above. I have full right to consent to the matters above, and I consent to same; (b) I hereby indemnify and hold harmless the facility, its employees, agents, medical staff, partners and affiliates from any cost or liability arising out of my lack of adequate authority to give this consent.

_____ _____
Signature of Patient Date Signature of Legally Responsible Person Date

_____ _____
Witness Signature Date Physician Signature Responsible for Anesthesia Date

_____
Physician Signature Responsible for Procedure Date