

PROCEDURE CONSENT

1. I, _____, for _____ authorize
(person signing consent) (myself or name of patient)
Dr. _____ and such associates and/or assistants as selected by him/her, to perform or direct the performance of the following operation and /or procedure:

2. My physician has explained to me the reasons for this procedure, the nature of the procedure, and possible alternatives to this procedure and their risk. I have also been informed of the possible risks and consequences of this procedure, including but not limited to: Infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia, stroke, and brain damage. These risks can be serious and even death can occur. I understand that the explanation I have received is not exhaustive and that there may be other remotes risks and consequences.

3. I understand that my operation may require anesthesia. The administration of anesthesia involves risk, most importantly a rare risk of reaction to medications, possibly causing death. I also understand that there are potential complications of all types of anesthesia, including local, moderate sedation, regional, and general, ranging from temporary and minor to permanent and serious. I have received no guarantees that my operation will be free from anesthesia complications.

I have been advised that dental devices such as dentures, bridges, caps, crowns, fillings, etc., are more subject to damage than normal teeth would be during surgical and anesthesia procedures. I have also been advised that all removable teeth should be removed by me before going to surgery and I agree that responsibility for loss or damage will be mine, if I fail to remove such teeth.

I request the administration of such anesthetics as are deemed necessary by the person responsible for these services, with the exception of: Privileging

4. I understand that during the procedure, other or different conditions may be discovered that require emergency, additional or different procedures than those planned, and I authorize the performance of such other procedures including the administration of blood or blood products which are in the exercise of professional judgment necessary and advisable, EXCEPT:

5. I consent to the disposal, by the authorities of the above-named facility, of any tissue, body parts, prosthetic devices, or foreign bodies which it may be necessary to remove during the procedure.

6. I understand I am responsible for arranging a ride home and that I am not to drive, operate equipment or drink alcoholic beverages for 24 hours following the procedure, EXCEPTION:

7. I also consent to the presence of medical, paramedical personnel and vendors during the procedure for educational purposes.


Advanced Cardiovascular Center

2335 Dougherty Ferry Rd. | Ste. A | St. Louis, MO 63122

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PATIENT IDENTIFICATION

PROCEDURE CONSENT (Continued)

8. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the procedure.

I have discussed the patient's/my condition and the proposed procedure with the physician and agree that the procedure should be performed.

I have read or had read to me, and understand, the contents of the form; and as such, I believe that I have adequate knowledge upon which to base consent to the proposed procedure.

Patient/Responsible Party

Date/Time

Relationship, if other than patient signs


Witness (Sign and print name if non-hospital personnel)

Patient is a minor, _____ years of age; or is unable to sign because: _____

PHYSICIAN DECLARATION: I have best explained the contents of this document and the administration of anesthesia to the patient/responsible party and have answered all the patient's/responsible party's questions. To the best of my knowledge, I feel the patient/responsible party has been adequately informed and has consented to the proposed procedure.

Physician Signature

Date _____ Time _____ AM PM



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