Millennium SURGICAL CENTER

2090 Springdale Road, St. A
Cherry Hill, NJ 08003

Patient Label

AUTHORIZATION FOR SURGICAL OR OTHER SPECIAL PROCEDURES

Patient's Name _____

1) I herby authorize and direct Dr. _____and associates or assistants of his/her choice to perform the following operation and any other procedure as he/she may deem necessary or advisable, on me, my child or ward:
_____
_____
_____

2) The basic procedures of my surgery, advantages, disadvantages, risks and possible complications as well as alternative treatments have been explained to me by the doctor. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. As with ALL types of surgery, there is the possibility of complications due to anesthesia, medication, reactions or other factors which may involve other parts of my body, including a possiblility of brain damage or even death. I am aware that there is a possibility of a hospital transfer in an emergency situation. Since it is impossible to state every complication that may occur as a result of surgery, the list of complications may be incomplete.

3) I herby authorize and direct the above named surgeon to arrange for such additional services for me, as he/she may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology and I hereby consent thereto.

4) I further consent to disposal by surgery center/hospital authorities, in accordance with its accustomed practice, of any tissue or parts, which may be removed.

5) I authorize the administration of transfusion of blood products as may be deemed advisable in the judgement of the anesthesiologists, patients attending physician, and/or his/her associates or assistants. I understand that blood transfusions are not always successful in producing a desired result. I understand that despite the exercise of due care the transfusion of blood or blood products is always attended with a possibility of some ill effects such as the transmission of hepatitis, AIDS, or certain other diseases, accidental immunization, or allergic reactions. I understand that emergencies do on occasion arise when 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.

6) I/We hereby authorize all doctors, pharmacies, Millennium Surgical Center or other institutions rendering care and treatment to furnish the responsible parties and/ or insurance companies with full information regarding treatment .(Including copies of their records.)

7) I acknowledge that I have been advised by Millennium Surgical Center personnel that I should not drive until the effects of any medications that I receive have worn off. This means I understand that I should not drive until the day after my operation, at the earliest.

8) I am aware that manufacturer's representatives and other observers may be admitted to the operatiing or treatment room if approved by the physician.

9) I understand that it is my responsibility to arrange for a responsible adult to drive me home and to be with me for twenty-four (24) hours following surgery.

10) I hereby consent to the use of video-taping or photography of my surgery at my surgeon's discretion and release the Millennium Surgical Center from all liability from claims of any kind for the taking and use of these photographs or tapes.

11) I am aware that my physician may have a beneficial equity interest in the Millennium Surgical Center and I was given written notice of Millennium Surgical Center's Patient Rights and Disclosure Information. I understand I can choose to go to another health care facility for this procedure, and it will have no effect on my relationship with my physician.

12) I release the Millennium Surgical Center from ANY responsibility for loss and/or damage to money, jewelry or other valuables brought into the Millennium Surgical Center.

13) In the event of an accidental exposure to my blood and/or bodily fluids by a healthcare provider, I consent to testing for an infectious disease, including HIV.

I AM STATING THAT I HAVE READ THIS CONSENT (OR IT HAS BEEN READ TO ME), AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS.

Patient's Signature_____ **Date** _____

Witness to Signature _____ **Date** _____

INFORMED CONSENT

I have explained to _____ (Patient, Guardian, or Proxy), the nature of the procedure, in layman's language, the necessity for the procedure its risks and benefits of those alternatives.

Surgeon's Signature _____ **Date** _____