



**TRESANTI SURGICAL CENTER**

5201 NORRIS CANYON RD, STE. 100  
SAN RAMON, CA 94583  
925-973-0605

THIS IS A COPY OF THE CONSENT YOU WILL BE ASKED TO SIGN PRIOR TO SURGERY. PLEASE TAKE A FEW MINUTES AND READ IT. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR NURSE OR PHYSICIAN. THANK YOU

**AUTHORIZATION AND CONSENT TO SURGERY**

DATE \_\_\_\_\_

AGE \_\_\_\_\_ SEX: M F \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_

I authorize \_\_\_\_\_ and associates or assistants of his choice to perform the following:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please INITIAL each Section:

1. \_\_\_\_\_ I consent to the performance of surgeries and procedures listed above in addition to any my physician may consider necessary or advisable in the course of the procedure. This authorization includes the administration of blood or blood product transfusions.
2. \_\_\_\_\_ I also authorize the use of other procedures, which are indicated to be for my well-being, including but no limited to: anesthesiology, pathology, and radiology.
3. \_\_\_\_\_ I agree to and am aware of the risks and complications of anesthetic to be given. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service.
4. \_\_\_\_\_ The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the physician. I have been given the opportunity to choose or reject this surgical or medical procedure.
5. \_\_\_\_\_ I accept this treatment and the risks involved because I believe it is to my own best interest to do so.
6. \_\_\_\_\_ No one has given me any guarantee and I know that no one can guarantee the outcome of any surgical medical procedures.
7. \_\_\_\_\_ It has been explained to me that a satisfactory result is expected but that the following are some of the complications or effects that could or may occur: Bleeding, Infection, Damage to Adjacent Tissues or Organs, Swelling, Pain, Suture Reaction, Delayed Healing, Scarring, Anesthesia or Medication Reaction, Recurrence, Additional Operations, and in rare instances, Paralysis, Death or other: \_\_\_\_\_
8. \_\_\_\_\_ I do not have Allergies or intolerance to anything except \_\_\_\_\_
9. \_\_\_\_\_ I was invited and encouraged to ask any questions I may have. All of my questions have been answered to my satisfaction.
10. \_\_\_\_\_ I have received written information regarding this procedure in consultation.

11. \_\_\_\_\_ I have/ have not seen photographs demonstrating a range of possible results.
12. \_\_\_\_\_ I consent to the disposal of any tissues or body parts which may be removed.
13. \_\_\_\_\_ I understand that the physicians involved in my case are acting at my request and under my authorization and that they are not acting at the request of the hospital.
  
14. \_\_\_\_\_ If complications arise, I agree to be admitted and treated at a hospital mutually agreed upon by my physician and myself if possible.
15. \_\_\_\_\_ I hereby acknowledge and am aware of the fact that my physician has ownership interest in this surgical facility. I have elected, however, to use this facility.
16. \_\_\_\_\_ I authorize the Tresanti Surgical Center to disclose complete information concerning his medical findings and treatment of the undersigned from the initial office visit until date of conclusion of such treatment to those individuals who in his/her sole determination are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review.
17. \_\_\_\_\_ I understand I have the right to make choices regarding life-sustaining treatment (including resuscitative measures)
  - \_\_\_\_\_ Yes, I have provided the facility with a copy of my Advance Directive/Living Will/Health Care Proxy. The facility has explained their policy regarding the honoring of this document and I agree to proceed with the proposed procedure as scheduled.
  - \_\_\_\_\_ I do not have or have not provided the facility with a copy of my Advance Directive/Living/ Will/Heath Care Proxy.
  - \_\_\_\_\_ I wish to obtain information on how I can obtain an Advance Directive/ Living Will/ Health Care Proxy.
18. \_\_\_\_\_ In the event of accidental exposure of my blood or body fluids to a physician, contractor, or employee of this facility, I consent to the testing for HIV and Hepatitis.

I have read and understand the content of this form and have received a copy.

SIGNATURE

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PATIENT     
  PARENT     
  GUARDIAN     
 circle one

WITNESS

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The Tresanti Surgical Center