Island eye Surgicenter

255 Glen Cove Road, Carle Place, NY 11514
Phone 516.877.2400 • Fax 516.877.1560

Place Label Here

PATIENT'S NAME: _____ **MEDICAL RECORD N0:** _____

CONSENT FOR OPERATION, ANESTHESIA, SPECIAL TREATMENTS OR PROCEDURES

1. I hereby authorize (Physician Name) _____, M.D. and /or such associates and assistants as may be designated by (him) (her) to treat the condition or conditions in connection with my (the above patient's) hospitalization in the Island Eye Surgicenter. I authorize them to perform the operation and/or diagnostic procedure(s) known as:

   Cataract Extraction with Insertion of Intraocular Lens of the eye

   _____

   _____

   _____

   _____

   The operation and/or diagnostic procedure(s) (has) (have) been explained to me in laymen's terms by Dr. _____ and I understand (its) (their) nature.

2. I have been made aware of certain risks, hazards, complications and consequences that are associated with the above operation, anesthesia, treatment(s) and procedure(s), as well as possible alternative modes of treatment.

3. It has been explained to me that during the course of an operation, unforeseen conditions may be revealed that necessitates an extension of the original procedure(s) or different procedure(s) than those set forth in Paragraph 1. I therefore authorize and request that the above named surgeon, (his) (her) associates and/or assistants perform such surgical procedures as are necessary and desirable in the exercise of their professional judgement. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the physician performing the authorized operation at the time the operation commenced.

4. I have also been informed that there are risks including but not limited to severe loss of blood, infection and/or cardiac arrest that are attendant to the performance of any surgical procedure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation, treatment(s) or procedure(s).

5. I further consent to disposal by the Island Eye Surgicenter, in accordance with its accustomed practice, of any tissue or parts, that may be removed.

6. I also consent to the admittance of observers to the Operating Room, and to photographing, televising or videotaping of the operation or procedure to be performed, including appropriate portions of my (the above patient's) body, for the purpose of advancing medical education and for other medical or scientific purposes provided my (the above patient's) identity is not revealed by either the pictures or the descriptive texts accompanying them.

7. I acknowledge and agree that I have had the opportunity to ask questions and that all my questions have been answered.

_____ Signature

_____ Relationship

_____ Witness

_____ Date

If an interpreter was utilized to obtain this consent, complete the following:

_____ Interpreter - Print Name

_____ Interpreter - Signature

_____ Interpreter Address

_____ Date

PHYSICIAN'S STATEMENT OF INFORMED CONSENT

I hereby certify that I have explained the nature, purpose, benefits, risk of, and alternatives to the proposed procedures/operations and/or anesthesia, and have fully offered to answer any questions. I believe that the patient (relative/guardian) fully understands what I have explained and answered.

_____ Physician's Signature

_____ Print Name

_____ Date

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