

Lakeside Ear Nose Throat & Allergy, LLC

GENERAL REQUEST AND CONSENT FORM

Patient's Name _____

I hereby authorize _____ to perform the following surgical procedure(s)

The benefits, risks, complications and alternatives to the above procedure(s) have been explained to me.

I understand that the procedure(s) will be performed under the supervision of my doctor. My doctor may use the services of other doctors or practitioners, or members of the resident staff as deemed necessary or advisable. I authorize my doctor and his or her associates and assistants to perform such additional procedures that in their judgment are necessary and appropriate for my diagnosis and treatment.

I consent to observers in the operating room in accordance with hospital policy. I consent to photography or video taping of my surgical procedure for educational purposes.

I agree to being given blood or blood products as deemed advisable during the course of my procedure. The risks, benefits, and alternatives to receiving blood or blood products have been explained to me.

I consent to the administration of sedation or analgesia during my procedure. The risks, benefits, and alternatives to receiving sedation or analgesia have been explained to me.

If anesthesia is required, I consent to the administration of anesthesia by members of the Department of Anesthesia. I also consent to the use of non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in addition to those resulting from the surgery itself.

Please initial one of the following statements:

___ To the best of my knowledge I am not pregnant

___ I believe I am pregnant

___ N/A

I certify that I have read and understand the above consent statements. I have been offered the opportunity to ask my doctor any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s).

Signature of Patient or Decision Maker

Date and Time

(Relationship to Patient if Decision Maker)

Signature of Witness

Date and Time

Signature of Physician

Date and Time