

Name of Patient: _____

I hereby consent to and authorize Dr/s. _____
(surgeon/physician), with such other assistants as he/she deems appropriate, to perform the following surgery or special procedure
on me at Sarasota Memorial Health Care System: _____

Specify the name of the surgical procedure(s), special procedure(s), treatment(s).

- I also consent to the performance of operation(s), procedure(s), and treatment(s) in addition to or different from that named above if, during the course of the operation, the above-named physician considers such addition or change necessary, appropriate, or advisable. I authorize the agents and employees of the Sarasota County Public Hospital Board to render such hospital care and services as are customary and necessary with respect to all such operation(s), procedure(s), and treatment(s).
- I also consent to a Surgical Physician Assistant (PA), Registered Nurse First Assistant (RNFA) or Certified Scrub Technician First Assistant (CSTFA) to assist in the first assistant role if needed during the procedure(s). These individuals may be assigned the day of the procedure(s) on an as needed basis (a list of hospital approved assistants that may participate in your care will be provided upon request). I understand that the assistants may perform important parts of the procedure, which may include, but are not limited to; incision and closing of operative site; altering, dissecting, cauterizing or removing tissue; harvesting leg vein(s) for grafting purposes; assisting with implanting devices.
- I also authorize and direct the above-named physician and/or his/her associates and assistants to provide such additional services as they deem reasonable and necessary arising from presently unforeseen conditions including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology.
- I am aware that vendors and/or sales representatives associated with equipment and supplies used for the procedure may be present in the operating room.
- I am aware that students may participate in my surgical care under the direct supervision of my physician/s.
- I have conferred with the above-named physician and/or other physicians about the nature and purpose of the procedure as stated above and the possibility that complications may arise or develop.
- Although I have been informed of the benefits to having the treatment, surgery, or special procedure, I fully understand that certain adverse events could occur as a result of or during the procedure including but not limited to pain, infection, laceration or puncture of internal organs, bleeding, nerve damage, and even death in rare cases.
- I consent to the administration of blood and/or blood components during the surgical procedure, and during the immediate post-operative period if my physician determines the administration of blood and/or blood components is warranted. I understand there are risks associated with receiving these products such as the transmission of diseases, infection, and other conditions affecting the body's systems.
- I understand that any tissues or parts surgically removed will be retained or disposed of by the facility in accordance with its customary practice.

**** PLEASE COMPLETE, REVIEW, AND SIGN BACK OF FORM ****

**SARASOTA MEMORIAL HEALTH CARE SYSTEM
INFORMED CONSENT FOR SURGERY AND
SPECIAL PROCEDURES**



<i>DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR</i>
PATIENT NAME
DATE OF BIRTH
DOCTOR:
PLACE PATIENT ID LABEL HERE

