KSC
Kamloops Surgical Centre

Patient Label

CONSENT FORM *** To be completed by Surgeon's Office****

I hereby authorize and request Dr. _____, along with any assistants he/she feels necessary, to perform upon me the following treatment, procedure, or surgical operation(s):

_____

_____

I also authorize the attending physician to provide any additional treatment or investigation that in his/her judgement may be advisable for my immediate well-being.

The nature of the planned operation has been thoroughly explained to me and I have decided to proceed with this procedure over other alternate methods. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made about the results of the operation or procedure planned. Furthermore, the risks and complications inherent in the operation have been explained to me and I accept these.

I further give permission to have such anaesthetics administered to me as the attending physician(s) or the anaesthetist deem necessary or advisable.

Pictures may be taken of the treatment site for record purposes. I understand that these photographs/videos will be the property of the attending physician. **I DO / DO NOT** agree to allow these pictures to be used for publication or teaching purposes. If I agree, I understand that my name and identity will be kept confidential and protected.

I further consent to the drawing and testing of my blood for risk assessment purposes in event of inadvertent exposure of doctors or clinic personnel to my blood or body fluids during the course of the procedure or pre or postoperative care and the release of the results of such testing to my physician and public health authorities in accordance with BC Centre for Disease Control policy.

I agree to keep the surgeon's office informed of my post operative progress and I agree to follow the instructions given for my post operative care.

I hereby acknowledge receiving a copy of the post-operative instructions which have been reviewed with me. I understand the advice and restrictions given and agree to abide by them. I will notify my doctor immediately if any unusual bleeding, respiratory problems, or acute pain occurs after my discharge from Kamloops Surgical Centre.

I have read the above information and understand its contents; I consent to the surgical procedure.

Signature of Patient or Legal Guardian: _____

Name (Please print): _____

Relationship (If Legal Guardian): _____

Witness: _____

Date: _____