Valley Surgery Center

Laser Procedure Consent

(A) I acknowledge and understand that the following procedure(s) which has (have) been described to me is (are) to be performed on the patient at Crescent City Surgery Center the ["Facility")

(B) Pregnancy Testing: If the Patient is female and unless I opt out below, I request and consent to the Facility performing a urine pregnancy test, as part of the Facility's routine pre-operative lab work due to the possible risks of anesthesia and certain medications on an unborn fetus, including birth defects and miscarriage. I understand a urine pregnancy test is generally accurate, but no pregnancy test is 100% reliable, and there is a possibility this test could miss an early pregnancy or have a false positive result. If the Patient believes she might be pregnant, it is her responsibility to notify her attending physician and anesthesiologist before any medication or anesthesia is given.

(C) DNR (Do Not Resuscitate) Order:

If I have consented to a do not resuscitate order ("DNR"), I UNDERSTAND AND ACKNOWLEDGE THAT my consent to a DNR order is temporarily suspended/canceled while I undergo any elective, invasive, interventional and/or operative procedure performed at this Facility. I WILL BE RESUSCITATED. This temporary suspension (cancellation) of a DNR order will remain in effect until I am discharged from the facility or transferred to a higher level of care.

(D) Photographs: I consent to the taking and publication of any photographs in the course of this operation for the purpose of treatment and/or medical education.

(E) Human Immunodeficiency Virus (HIV) and Hepatitis Testing: I understand that in the event a health care worker sustains a significant exposure to my blood or body fluids, I may be asked to undergo testing for HIV, the virus that causes AIDS, and / or hepatitis. The results of any test will be confidential and will be treated in accordance with Indiana law. I understand that, in accordance with Indiana law, a positive HIV test result will be reported to the county health department with sufficient information to identify me. Furthermore, I hereby authorize Cresent City Surgery Center and/or my physician or other health care provider to disclose such HIV test results to any third party payor, as appropriate for processing and payment.

(F) No Guarantees: I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

(G) Use/Disposal of Tissue: I hereby authorize the Facility to retain, photograph, preserve, and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissues taken from my body during my procedure or treatment. Specimens or tissues removed may be sent to a laboratory for further testing or examination by a pathologist.

(H) I consent to the administration of anesthesia as required for the surgery. Should I have any questions regarding this, I will have the opportunity to discuss them with the anesthesiologist prior to surgery.

(I) I authorize the admittance of observer and/or Manufacturer's Representatives as deemed appropriate by my surgeon.

(J) Possible Complications of The Procedure(s):

a) Retinal detachment. This can cause loss of vision, but if detected early, corrective surgery is usually successful.

b) Cystoid macular edema. Caused by fluid accumulation in the center of the retina, this can cause significantly decreased vision.

c) Glaucoma. Characterized by increased pressure of the eye, this condition can usually be treated successfully, but can occasionally cause loss of vision.

Any of the above potential complications may vary from mild to severe. In severe instances, they could lead to blindness; heart or brain damage; inflammation within the eye; or even death.

(K) Certification and Signatures:

I certify that I understand the information regarding my procedure and that I have been fully informed of the risks and possible complications thereof, as well as, medically acceptable alternatives to my procedure. I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. I hereby authorize and permit the physician and whomever he/she may designate as his/her assistants to perform upon me the named procedure(s).

If any unforeseen condition arises during the procedure calling in his/her judgment for additional procedures or medications, I further request and authorize him/her to do whatever he/she deems advisable.

I certify that I have been informed that I may receive a sedative for this procedure. I understand that I should not drive, operate machinery, make critical decisions, or drink any alcohol until the day after my procedure. I have signed this form prior to receiving sedation.

I voluntarily assume the risk of any injury damage to me and my unborn child if I am pregnant yes, no, n/a

I understand that certain procedures and/or drugs may be harmful to an unborn child. Yes, no, n/a

I refuse the facility urine pregnancy test yes, no, n/a