Abilene Surgery Center, LLC
Disclosure and consent – Medical and Surgical Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I (we) voluntarily request **( ) Dr. Sunil Patel. M.D** and/or **( ) Dr. S Young Lee M.D**. and/or **( ) Dr. Grant P. Janzen M.D**. and/or **( ) Dr. Eric M. Zavaleta M.D. ( ) Dr. Courtney M. Crawford, MD** as my physician(s), and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as: **( )** Right **( )** Left Eye: **( )** Retinal Detachment **( )** Macular Hole **( )** Glaucoma **( )** Epiretinal Membrane **( )** Vitreous Hemorrhage **( )** Proliferative Diabetic Retinopathy **( )** Vitreous Opacities **( )** Luxated Lens **( )** Vitreomacular Traction **( )** Posterior Vitreous Detachment **( )** Endophthalmitis **( )** Blind Painful Eye **( )** Other: _____

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: Surgery **( )** Right **( )** Left eye: **( )** Pars Plana Vitrectomy **( )** Membrane Peel **( )** Laser **( )** SF6 Gas **( )** C3F8 Gas **( )** Ahmed Valve **( )** Scleral Buckle **( )** Silicone Oil **( )** Oil Removal **( )** Scleral Buckle Removal **( )** Pars Plana Lensectomy **( )** Sutured IOL **( )** Enucleation ( ) Other: _____

I (we) understand that my physician may discover other or different conditions, which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.
I (we) understand that no warranty or guarantee has been made to me as to result or cure.
Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in arteries and veins, lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure.

1. Complications requiring additional treatment and/or surgery
2. Recurrence or spread of disease
3. Partial or total loss of vision
4. Pain
5. Disfigurement and or loss of eye
6. Infection
7. Bleeding
8. Death

TRANSFUSION CONSENT: () (applicable) (X) (not applicable to this procedure)
I (we) (DO) (DO NOT) consent to the use of blood and blood products as deemed necessary.
I (we) understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction, which may include Kidney Failure or Anemia, Heart Failure, Hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other Infections.

I (we) understand that anesthesia/sedation involves additional risks and hazards but I (we) request the use of anesthetics/sedation for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia/sedation may have to be changed possibly without explanation to me (us).
I (we) understand that certain complications may result from the use of any anesthetic/sedation including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards, which may result from the use of general anesthetics, range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.
I (we) consent to the disposal by hospital authorities of any tissues or body parts, which may be removed.
I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia/sedation and treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent
I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, that the blank spaces have been filled in and that I (we) understand its contents.

TIME: _____ P.M. A.M.

WITNESS: _____

Abilene Surgery Center
5601 Health Center Dr., Abilene, TX 79606

DATE: _____

_____
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON

I have informed and explained to the patient/patient's surrogate decision-maker the nature, purpose, consequences, risks, benefits of and alternatives to the procedure/treatment; and answered all the questions, if any, to the patient's/patient's surrogate decision-maker's satisfaction. Further, the patient/patient's surrogate decision-maker has acknowledged his/her understanding of the same. And the patient/patient's surrogate decision-maker has given consent.

Physician's signature:_____ Date: _____

Revised for ASC 3-13-13, 7-2-13; 11-20-2013; revised 05/01/2015; Rsvd 08/04/2016