BRANDYWINE SURGERY CENTER
1224 Baltimore Pike, Suite 100
Chadds Ford, PA 19317
P:(610) 459-1559
F: (610) 459-8010

REQUEST AND CONSENT TO OPERATION

I _____ request and give consent to Dr. Christopher Saunders to perform the following procedure(s):

_____

_____.

The nature and purpose of this operation has been fully explained to me; and the part(s) of my body which will undergo this operation has been described to me. My physician has fully explained the risks, complications, and benefits to the above procedure(s) to me. I have been informed of alternatives to this surgery including the option of no treatment. I have also been informed of the risks and benefits to having surgery in an ambulatory surgical facility versus the hospital.

I am aware that no guarantee or assurance as to the results of the operation have been made and I have been told that no guarantee of results could be made. By signing this consent, I agree that all the foregoing has taken place to my satisfaction.

Therefore, I authorize my physician above, any additional physicians listed here, _____N/A_____, and the associates and assistants whom he might designate to perform this operation together with any preoperative or postoperative treatment upon me. I authorize the operating surgeon to perform any other procedures which he may deem necessary in attempting to improve the condition for which I am being treated or any unforeseen condition that he may encounter during the operation.

I also consent to the administration of anesthesia, general, MAC, or local, to be applied by or under the direction of the Anesthesia Department and/or the operating surgeon, and the use of such anesthetics and medications as deemed advisable.

I authorize my doctor, and/or such assistants as he may engage for this purpose, to take such photographs required for pre and post operative analysis or educational purposes.

Please initial one of the following statements (females only):

____ To the best of my knowledge I am not pregnant. ____ I believe I am pregnant.

I authorize my doctor to disclose complete information concerning his medical findings and treatment for the undersigned, from the initial consultation until date of conclusion of such treatment, to those individuals who, in my doctor's sole determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, and peer review.

_____ _____
Signature of Patient or Parent/Legal Guardian of minor Date

*_(_____)_____
***REQUIRED**: Please provide a phone # where we can reach you **on the day of surgery** in the event of any schedule changes.

_____ _____
Signature of Witness Date

_____
Witness Print Name

_____ _____
Signature of Doctor or Practitioner Date