1. I hereby authorize the performance of the following operations or procedures upon me: _____
_____
_____
_____
to be performed under the direction of Dr.(s) _____
and such assistants or associates as he/she may designate. I consent to the performance of such operation(s) and/or procedures(s) in addition to or different from those now contemplated, whether or not arising from present or unforeseen conditions, which the above named doctor(s) or his/her associates may consider or advisable during the course of the operation.

2. I consent to the administration of such anesthetics as may be considered appropriate by the physicians responsible for this service. The Anesthesiologist will discuss the anesthetic plan to include benefits, risk and alternatives with me and/or my representatives before the procedure begins.

3. For the purpose of advancing medical education, I consent to the admittance of qualified observers to the Operating Room and the taking of photographs, x-rays, or videotaping.

4. I consent to the disposal or retention by the UPMC Surgery Center or release to the manufacturer of any implant device that may be removed, and I consent to the disposal or retention by UPMC Surgery Center of any tissue removed from me.

5. The purposes, nature, risks of and the alternatives to the operation(s) and/or procedure(s) have been explained to me to my satisfaction by the above named doctor or his/her associates, and I realize that there is no certainty, or guarantee as to the results of the operation(s) and/or procedure(s). All of my questions have been answered to my satisfaction.

   Additional Risks: _____
   _____

6. The comparative risks, benefits and advantages associated with performing the procedure in an outpatient surgery center instead of a hospital has been explained to me. I understand I may require hospital admission in the event of medical need.

7. I intend to be legally bound by this consent, which I am signing voluntarily after it has been completed and after having read and fully understanding it.

8. I understand that all life-saving procedures will be performed during the surgical procedure.

Patient_____ _____ _____ _____
(or Authorized Person) (Signature) *(Printed Name)* *(Date)* *(Time)*

_____
(Relationship to Patient)

_____ _____ _____
(Witness of Signature) *(Date)* *(Time)*

PHYSICIAN'S CERTIFICATION

I hereby certify that the patient or person authorized to consent for the patient did so after having been advised orally as to the nature, purpose, benefits, risks of, alternative options (including no treatment), risks of alternative options, likelihood of achieving goals of care, potential problems that may occur, the matters referred to in the consent, and after having received answers to any questions. By signing below, I indicate that the patient or person authorized to consent fully understands what I have explained and answered.

Physician_____ _____ _____ _____
(signature) (printed name) (date) (time)

UPMC LIFE CHANGING MEDICINE

UPMC SURGERY CENTER/CARLISLE
INFORMED CONSENT TO OPERATION, DIAGNOSTIC AND THERAPEUTIC PROCEDURES, AND ANESTHESIA

PATIENT IDENTIFICATION