

Advanced Pain Management Institute

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CONSENT FOR OPERATION, ANESTHESIA, OR OTHER PROCEDURE

PATIENT: _____

I hereby authorize **Dr. Valery D. Tarasenko** and his chosen associates and assistants to perform the following operation(s) and/or procedure(s):

1. The purpose and nature of the Medical-Surgical procedure, possible alternative methods of treatment and risks involved and the possibility of complications have been explained to me by the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained.
2. I recognize that during the course of the procedure unforeseen conditions may necessitate additional or different procedures than those set forth in paragraph one. I therefore further authorize and request that the above named physician, his assistants or his designees perform such procedures as are in his professional judgment necessary and desirable including but not limited to procedures involving pathology and radiology. The authority granted under this Paragraph shall extend to remedying conditions that are not known to the physician at the time the procedure is commenced.
3. I consent to the administration of anesthesia and such anesthetics as may be considered necessary or advisable by the physician/anesthesia staff responsible for this service.
4. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of this procedure.
5. I am aware that inherent in the performance of any operation/procedure there may be risks such as (but not limited to) infection, bleeding, cardiac arrest, respiratory arrest, shock, embolism, and blood loss and that these or others could possibly cause permanent disability or death. I understand that I may inquire of my physician for additional information.
6. For the purpose of medical education or training, I consent to the admittance of the observers to the operating room and to the taking of photographs to be limited to the surgery site.
7. I also consent to the performance of diagnostic tests appropriate for the condition of or to ascertain the condition of the patient.
8. I understand that the explanations and answers that I have received are not necessarily exhaustive and that other, more remote risks, complications, or consequences may arise. I understand that a more detailed and complete explanation of any of the foregoing matters will be given to me by the physician if I do so desire but acknowledge that I do not desire any further explanations or answers.
9. I hereby authorize to preserve for scientific purposes or to otherwise dispose of the dismembered tissue, parts, organs, or implanted devices resulting from the procedure described above.
10. Photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him. Such photographs may be utilized for scientific and/or teaching purposes as long as my identity is not revealed.

I certify that I have read and fully understand all paragraphs of the foregoing; that the explanations and answers reoffered to herein were given and that I understand them; that any questions that I had have been answered; and that blanks requiring condition were filled in before I signed.

Signature _____
(Patient/Parent/Conservator/Guardian)

_____ Date

If signed by other than patient, indicate relationship: _____ Witness: _____