Progressive Surgical Associates

INFORMED CONSENT FOR INCISION AND DRAINAGE OF AN ABSCESS OR HEMATOMA

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the alternatives, the risks associated with the alternatives and all Please initial and date directly below this paragraph indicating	of your questions have been answered.
Patient's Initials or Authorized Representative	Date
I,, hereby authorize Drassociates or assistants the doctor deems appropriate, to per or hematoma.	
The doctor has explained to me the potential benefits of the no certainty that I will achieve these benefits and no guarant outcome of the procedure. I also authorize the administratio deemed advisable or necessary for my comfort, well-being, a	n of sedation and/or anesthesia as may be
The doctor has explained to me that there are risks and possivith the procedure including, but not limited to, blood loss, to complications, blood clots, loss of or loss of use of body part, scarring, reaction to local anesthetic if used, need for further need blood or blood products these carry a risk of contractin Further, any of these risks or complications may require furth procedure, which I expressly authorize	transfusion reactions, infection, heart other neurological injury, recurrence, surgery and/or death. I understand that if I g HIV/AIDS, hepatitis, or other diseases.
In permitting my doctor to perform the procedure, I understance revealed that may necessitate change or extension of the orientanthose already explained to me. I therefore authorize and his/her assistants, or his/her designees perform such procedexercise of his/her professional judgment.	ginal procedure or a different procedure(s) d request that the above-named physician,
In the unlikely event that one or more of the above inherent covering physician will take appropriate and reasonable step	

be available to me and my family to address our concerns and questions.

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The reasonable alternatives to the procedures, as well as the risks to the alternatives, have been explained to me. The alternatives include, but are not limited to, continued observation, complete surgical excision, and repeated treatments with applied medication.

I hereby authorize the doctor/and or the hospital or surgical center to utilize or dispose of removed tissues, parts or organs resulting from the procedure authorized above.

I consent to any photographing or videotaping of the procedure that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

			/
Signature of Patient or Authorized Representative	Relationship	Date	Time
☐ The Patient/Authorized Representat	tive has read this form or had it read	d to him/her.	
☐ The Patient/Authorized Representat	tive states that he/she understands	this information	on.
☐ The Patient/Authorized Representat	tive has no further questions.		
		_	
Signature of Witness	Date Time		
CI	ERTIFICATION OF PHYSICIAN:		
I hereby certify that I have discussed w material risks, alternative therapies and			•
Physician:	Date/Time		/

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USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows
Foreign language (specify)
Sign language
Patient is blind, form read to patient
Other (specify)
Interpretation provided by
(Fill III hame of interpreter and Title of Relationship to Patient)
Signature (marriadar romanig rissistance) Dute Inne