

**CHARLOTTE EENT ASSOCIATES**

**Consent for Operation,  
Procedure or Treatment**

**Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

(1) I give my permission for the following operation, procedure or treatment: \_\_\_\_\_  
CATARACT EXTRACTION WITH INTRAOCULAR LENS IMPLANT EYE

(2) Physician name SCOTT L. JABEN MD will perform this operation or procedure with any assistants or associates that he chooses at the selected facility.

(3) I understand the following and agree that my doctor has discussed them with me:

- (a) nature of my illness
- (b) nature and purpose of the operation, procedure or treatment
- (c) benefits of having the operation, procedure or treatment
- (d) usual and most often risks of the operation or procedure; this includes the risk that such operation, procedure or treatment may not accomplish the goal of the operation or procedure
- (e) all reasonable options and their risks
- (f) the risk of no operation, procedure or treatment
- (g) I have had a chance to ask questions; my questions have been answered to my satisfaction
- (h) no guarantees have been made as to the results of this operation, procedure or treatment.

(4) Unexpected events may occur during the operation. These events may increase the length of the initial operation or require a different procedure from that listed above. If this occurs, I give permission for my doctor, his assistants and/or associates to perform such surgical procedures as they, in their medical judgment, determine to be necessary.

(5) I give my permission to be given anesthesia or sedation as necessary for my operation, procedure or treatment.

(6) I request the administration of any blood or blood products necessary or recommended by my doctor. I have been told the following:

- (a) the possible need for blood or blood products
- (b) the usual and most frequent risks and benefits
- (c) options related to the administration of these products.

(7) I permit the disposal of any removed tissue, organs or body parts. I also permit the facility to keep any removed tissue, organs or body parts that normally would be thrown away. These items may used for research, teaching or the treatment of others. I understand that the hospital will keep certain tissue for the time required by law.

(8) I give my permission for photographs, videotapes or closed circuit television, and publication of the operation or procedure. I understand that I will be asked to sign an authorization or any identifying information will be removed.

(9) I give my permission for persons to observe in the Operating Room. The reason is for medical education, supplying needed medical equipment or supporting the health care team. This includes persons selling medical equipment.

(10) I understand that any of the above that I do not consent to will be lined through, dated and initialed.

By signing here, I fully understand the contents of this document and that any rights and obligations that relate to my care shall apply only to the facility in which I am being treated. I also have the ability to make and communicate my health care decisions.

\_\_\_\_\_  
Patient Signature Date/Time

\_\_\_\_\_  
Signature of Authorized Person Date

\_\_\_\_\_  
Witness Signature Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature Date

\_\_\_\_\_  
Physician Signature Date

Limited English proficiency or hearing impaired:

- Interpreter \_\_\_\_\_
- Interpreter Refused

Physician signature affirms the information in #3 above.  
(Name/Number of person/Service chosen/Used)

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or Treatment**

(Patient Label / Addressograph)