Philadelphia Surgi-Center

PROCEDURE CONSENT

1. I hereby authorize **Dr. Sofia Lam** to perform upon (Patient name) _____

the following surgical and/or medical procedures:

Decompressive Neuroplasty	**Decompressive Neuroplasty with Lysis of Adhesions**
Cervical Neuroplasty	**Cervical Neuroplasty with Lysis of Adhesions**
RFL of S1 Joint	**Facet Joint Injection**

The risks include new pain, worse pain, bleeding, infection, headache, paralysis, permanent nerve damage, weakness, loss of bowel and/or bladder function, urinary retention, seizures, respiratory depression, tachycardia, bradycardia, drug reaction, drug reaction, lung collapse, avascular necrosis, death.

2. I understand that the procedure(s) will be performed under the supervision of the above-named physician who is authorized to utilize the services of other physicians or licensed healthcare professionals as he deems necessary or advisable in the performance of the procedure(s) listed above.

3. I understand that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in Paragraph one. I therefore, authorize and request that the above-named physician perform such procedure(s) as are necessary and desirable in the exercise of their professional judgement.

4. I consent to the admission of local, regional or monitored anesthesia (MAC) to be applied by or under the direction of my physician. I realize that the administration of medication or anesthesia may impair my mental alertness for several hours, and I will not make any decisions or participate in any activities that depend on full mental alertness during that time. I will not drive a vehicle or operate heavy or dangerous machinery during that time.

5. I hereby allow the above-named physician to examine or photograph portions of my body, use or authorize the use for education, research or development purpose(s), and dispose of any tissue that may be removed by a physician(s) as necessary during the course of my treatment.

6. I understand the nature and purpose of the procedure(s), the benefits, possible alternative methods of diagnosis or treatment, the risks involved, the possibility of complications and the foreseeable consequences of the procedure(s) and the possible results of non-treatment. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

7. I certify that I have read and fully understand the above consent for my procedure(s). In addition, I have been afforded the opportunity to ask whatever questions that I may have regarding the procedure(s) to be performed and that they have been answered to my satisfaction.

8. The Risks, Benefits and Alternatives of an Ambulatory Surgical Facility have been explained to me. I understand that all physicians at the Philadelphia Surgi-Center have varying degrees of financial interest in the facility and they have offered me an alternate site for the procedure..

X _____ _____

Patient / Authorized Representative Physician Signature
(State relationship to patient)

_____ _____

Witness Signature Date