First Hill
SURGERY CENTER

BREAST SURGERY CONSENT

Patient Name: _____

Patient ID: _____ **Patient DOB:** _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1. MY PROCEDURE

I hereby give my consent for Dr. _____to perform:

☐ Left _____

☐ Right _____

☐ Bilateral _____

I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to treat and evaluate abnormalities in my breast.

I understand that the procedure or treatment can be described as follows:

An incision will be made and the abnormality will be removed. Some patients will possibly have a separate incision made in their armpit for sentinel lymph node excision; possible axillary lymph node dissection; and possible tissue transfer techniques.

This procedure may require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2. MY BENEFITS

Some potential benefits of this procedure may include:

- Diagnosis and removal of breast abnormality
- Removal of breast cancer for cure and staging

3. MY RISKS

I understand that there are potential risks, complications and side effects associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

These could include but may not be limited to the following:

infection; bleeding; cosmetic changes/issues; change in sensation, appearance and shape of the breast; seroma; lymphedema; possible numbness near the incision or behind the arm; possible nerve injury; chronic pain; other rare complications are also possible.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

I understand these special risks of this procedure and that these can be affected by obesity, diabetes, smoking, and other factors.

4. MY CONSENT

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures.**

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required.**

I understand that frequently permanent marker clips are placed for future reference on my mammograms.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to observation only. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed procedure and decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Signature:_____ Date: _____ Time: _____

Patient is unable to consent because _____. I therefore consent for the patient.

Authorized Consenter's Signature: _____ Date: _____ Time: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____