BLEPHAROPLASTY DISCLOSURE & CONSENT
MEDICAL & SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Mark L. Mayo, MD as my physician, and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained to me as: _____

_____

I (we) understand that the following surgical, medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: _____

_____

I (we) understand that my physician may discover other or different conditions which require additional or different procedures than those planned.

I (we) authorize my physician, and such associates, technical assistants and other healthcare providers to perform such other procedures which are advisable in their professional judgments.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure: *Refer to disclosure list A/ Disclosure B.*

CONSENT FOR BLOOD PRODUCTS
I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary.

_____
SIGNATURE

EYE CENTER OF TEXAS
Leaders in Eye Care

Revised 5/2023

CONSENT FOR DISPOSAL OF TISSUE/ LIMBS

I (we) authorize my physician and the hospital to dispose of, in accordance with the accustomed practice, any tissue or body parts surgically removed.

N/A _____

SIGNATURE

CONSENT FOR ANESTHESIA

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result form the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards, which may result from use of general anesthetics, range from minor discomfort to injury to vocal cords, teeth, or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I (we) have been given an opportunity to ask questions about my condition, alternatives, forms of anesthesia and treatment, risk of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

N/A _____

SIGNATURE

I (we) certify this form has been fully explained to me, that I (we) have read it or have it read to me, that the blank spaces have been filled, and that I (we) understand its contents.

_____ **DATE** _____ **TIME** _____ a.m / p.m.

PATIENT SIGNATURE OR LEGAL GUARDIAN SIGNATURE

_____ **DATE** _____ **TIME** _____ a.m / p.m.

WITNESS SIGNATURE