Dr. George M Wadie, MD, FACS, FAAP

Carolina Pediatric Surgery

600 New Waverly Place #203
Cary, NC 27518

Office: (919) 858-7020
Fax: (253) 859-5695

Consent to Medical/Surgical Office Procedure

I (or my authorized representative, i.e., parent guardian), _____, consent to the medical/surgical procedures outlined below to be performed by _____ and his/her staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities.

The proposed medical/surgical procedure is _____ for the diagnosis/treatment of _____.

The procedure has been explained to me in terms that I understand. **The explanation included:** 1) The nature and extent of the procedure to be performed. 2) The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences. 3) General risks which may include pain, scarring, bleeding and infection. 4) The benefits of the procedure. 5) The estimated period of incapacity or convalescence, if any. 6) The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I was given the opportunity to ask any questions regarding the procedure and I have had those questions answered to my satisfaction. I understand that I may consult or could have consulted with another physician about this procedure. I understand that I have the right to refuse any surgical treatment recommended at any time prior to its performance.

I authorize my physician to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment. If any unforeseen condition arises during this procedure which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize my physician to do whatever he/she deems advisable on my behalf.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I authorize the physician performing the procedure, or his/her staff, associate, or assistant to whom the physician may assign the responsibility, to use his/her discretion in disposing of or using any tissue that may be removed during the procedure set forth above, subject to the following conditions (if any):_____

Medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my physician to perform the above discussed procedure.

Patient/Guardian Name: _____Relationship: _____ Signature: _____Date_____
Witness Name: _____ Signature: _____Date _____

Physician Name: _____ Signature: _____ Date _____