CONSENT TO PROCEDURE OR SURGERY
EXCISION OF SEBACEOUS CYST / LIPOMA

1. I authorize and consent St. Luke’s Estes Surgical Associates and such assistants as may be selected by him/her, to treat
the following condition: SEBACEOUS CYST / LIPOMA

2. I authorize and consent to the performance of EXCISION OF SEBACEOUS CYST / LIPOMA

(MEDICAL AND LAY DESCRIPTION OF PROCEDURE. PLEASE INDICATE RIGHT OR LEFT WHERE APPROPRIATE.)

Upon MYSELF by St. Luke’s Estes Surgical Associates and such associates and/or designated assistants
as may be selected by the physician/operator.

3. The benefits and purpose of the operation and/or procedure have been explained to me in language I understand by
Dr. as well as the risks, alternatives and complications pertaining to the
above procedure/surgery which include but is not limited to: infections, deep vein thrombosis, blood clots to the lungs,
wound healing problems, complications from extensive blood loss, including shock and possible death.

4. The possible consequences of not undergoing the procedure have been explained to me.

5. I understand and consent to the administration of conscious sedation under the direction of my doctor. I understand that
this is a type of anesthesia and there are risks associated with it's use. This includes but is not limited to: recall of
intraprocedure/operative events, a lack of awareness lasting several hours post procedure/operation and allergic reaction.
I understand after receiving medication for conscious sedation it is not safe for me to drive a car for at least 8 hours.

6. Should any conditions be revealed at the time of surgery not recognized prior to surgery or as a result of the procedure
performed, I authorize my physician and/or designated associate to perform those additional procedures, which may be
deemed necessary at the time of surgery.

I am aware that there exists in any operation and/or diagnostic procedure some degree of risk and incidence
of complications in spite of all reasonable and customary precautions taken by the physician and St. Luke’s
Hospital and Health Network to prevent and minimize these risks. I ACKNOWLEDGE THAT NO GUARANTEE
OR ASSURANCE HAS BEEN MADE TO ME AS TO THE RESULT OF THE ABOVE NAMED PROCEDURE.

7. I understand and consent that all procedures, will be performed under the direct supervision and guidance of a St. Luke’s
Hospital and Health Network staff physician who is professionally qualified. I understand and consent that, it may be
necessary for an equipment consultant to be present during the surgical procedure at the discretion of the physician.

8. I understand that this hospital is a teaching hospital and that the presence, observation and or participation in my care of
those involved in training programs may be necessary.

9. I understand and consent to the preservation of any tissues or organs removed during my procedure for research or
teaching purposes. I also consent to the removal & disposal, by the appropriate hospital authority of any tissue
specimens or body parts during the course of surgery.

☐ Allentown Campus  ☒ Bethlehem Campus  ☐ Miners Memorial Campus  ☐ Quakertown Campus  ☐ Other ________________
10. I understand and consent to St. Luke's Hospital and Health Network's examination, photographing and/or recording by sound and/or video in whole or in part in the course of surgery, for scientific and educational purposes. It is understood that these will be treated with the utmost respect and strict confidentiality.

☐ I DO NOT consent to photographing or recording by sound and/or video. ____________________________

PATIENT/GUARDIAN INITIAlS

11. I understand and consent to all blood transfusions deemed necessary before, during, and after the procedure. The risks, benefits, and alternatives to blood product utilization have been explained to my satisfaction. The risks include, but are not limited to hepatitis and AIDS. There is also a risk of transfusion reaction, which in rare cases can lead to death.

☐ I DO NOT consent to receiving blood and/or blood products. ____________________________

PATIENT/GUARDIAN INITIAlS

12. I authorize the hospital to release my social security number to the manufacturer of an implant that may be implanted during my hospital stay. NOTE: This information will only be used to track the location of patient in the event of problems with the implant.

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND COMPLETELY THE INFORMATION ON THE CONSENT TO PROCEDURE OR SURGERY, THAT ALL EXPLANATIONS REFERRED TO WERE OFFERED, THAT ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND ANY STATEMENTS NOT APPLICABLE HAVE BEEN CROSSED OUT PRIOR TO MY SIGNATURE.

__________________________________________
Patient's Signature/Date/Time

I have explained to the patient (legal guardian/representative) the nature of the above procedure or treatment as well as the reasonably anticipated risks, complications and alternatives to such treatment.

__________________________________________
Physicians Signature/Date/Time

IF A PATIENT IS UNABLE TO CONSENT (I.E. MINOR OR INCOMPETENT)

Reason: ____________________________________________

__________________________________________
Signature of Authorized Person/Date/Time

Relationship: ______________________________________