NEW ENGLAND WOUND CARE, LLC

Patient ID# _____

Consent for Surgical and Diagnostic Procedures

Patient Name:_____ Date of Birth:_____

I authorize the performance of the following operation/procedure (s):

_____Wound Care/Debridement_____

To be performed by Dr. Waien / Kamille Oborne, PA, or Laura Quattruci, NP.

The practitioner has told me about: (l) the nature of the condition; (2) thy nature and purpose of the procedure; (3) the nature and probabilities of the risks, including possible complications and side effects; (4) the benefits to be reasonably expected; (5) the likely results of refusing this treatment; and (6) the available alternatives, including their risks and benefits. I understand that besides these specific risks, there are other possible risks that accompany any procedure and that the practitioner has made no guarantees or assurances about the results of the procedure.

I understand that unforeseen conditions may arise that the practitioner may determine requires additional or different treatment from what is described in this form. If that occurs, I authorize the practitioner to provide that treatment. I further understand that a resident, medical student, physician assistant, or student in another clinical program may participate in the procedure as part of the medical team. A representative of a medical device manufacturer also may be present.

I consent to the photography or video recording of the operations or procedures to be performed for medical, scientific or educational purposes. I understand that New England Wound Care, LLC may dispose of leftover tissue or use or transfer it for scientific, research, educational or commercial purposes. No one will know that the tissue came from me.

Unless I have specifically refused that I do not want blood or biological products, I understand blood or biological products will be used if the practitioner determines that the likely benefits would outweigh the risks. The practitioner will decide the amount and type of blood product based on the needs. I understand the risks and benefits, including serious infectious diseases such as hepatitis or AIDS, fever or allergic reactions, the destruction of transfused cells, or rarely death.

Complete if applicable: I do not authorize the following procedure or treatment or biological product/tissue: I understand that risks may occur because of the refusal and they have been explained to me.

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_____

I have read and understand this consent for treatment. I have received the explanations described and all required statements were completed before I signed my name. My questions have been answered to my satisfaction. I understand I can withdraw my consent at any time before the beginning of the procedure.

	Signature	Date and Time
Patient or Authorized Person and Relationship	X	
Witness		
For Telephone Consent, signature of second witness		
Interpreter, if applicable		
PRACTITIONER CERTIFICATION: I have explained to the patient/authorized representative the nature and purpose of the procedure, the alternatives, the risks involved in both the recommended procedure and in the alternatives.		
Practitioner Signature:		