NEWCare
New England Wound & Ostomy Care

CONSENT FOR SURGICAL PROCEDURES

Patient Name: _____ **DOB:** _____

I authorize the performance of the following procedure(s): Debridement and/or Cauterization to be performed by a practitioner of New England Wound Care, LLC (NEWCare).

The practitioner has explained to me:

1. The nature of my condition
2. The nature and purpose of the proposed procedure
3. The reasonably foreseeable risks, including possible complications and side effects
4. The benefits that may reasonably be expected
5. The likely results of refusing the recommended treatment
6. Reasonable alternative treatments, including their risks and benefits

I understand that, in addition to the risks specifically discussed, there may be other unforeseen risks associated with any medical or surgical procedure. I acknowledge that no guarantees or assurances have been made regarding the outcome of the procedure.

I understand that unforeseen conditions may arise during the course of treatment that, in the practitioner's judgement, may require additional or alternative procedures or treatments. If such conditions arise, I authorize the practitioner to perform such procedure or treatments as deemed necessary. I further understand that a resident, medical student, physician assistant, or student enrolled in another clinical training program may participate in my care as part of the medical team. A representative of a medical device manufacturer may also be present, if applicable.

☐ I have read and fully understand this consent for treatment. I have received the explanations described above, and all required statements were completed prior to my signing this document. My questions have been answered to my satisfaction. I understand that I may withdraw my consent at any time prior to the start of the procedure.

☐ I do not authorize the Debridement and/or Cauterization procedure. I understand that risks may occur because of the refusal, and they have been explained to me.

_____ Date and Time: _____
(Patient or Authorized Representative Signature)

_____ Date and Time: _____
(Witness Signature)

PRACTITIONER CERTIFICATION: I have explained to the patient/authorized representative the nature and the purpose of the procedure, the alternatives, the risks involved in both the recommended procedure and in the alternatives.

_____ Date and Time: _____
(Practitioner Signature)