Thyroidectomy/Parathyroidectomy CONSENT

The undersigned consent(s) and authorize(s) R. Bruce Redmon, M.D. and whomever he may designate as his assistants to perform a Thyroidectomy or a Parathyroidectomy on ____________________________ (name of patient).

I/we understand there are risks associated with my/my child's surgery, which may include, but are not necessarily limited to preoperative and postoperative Bleeding, Infections, Scar of the neck, Temporary drain in the neck, possible injury to nerves controlling Vocal Cords with possibility of hoarseness that could be temporary or permanent, injury to parathyroid gland with hypocalcaemia that could be temporary or permanent, or respiratory obstruction. There are also risks regarding anesthesia that should be discussed by the anesthesiologist or their staff.

The intention of this consent is to grant authority to Dr. Redmon to perform any and all examinations, treatments, therapy, cures, anesthetics, operations and diagnostic procedures, which may now, or during the course of the patient’s care, be deemed advisable or necessary. If any unforeseen condition arises in the course of the procedure calling in Dr. Redmon’s judgement for procedures in addition to or different from those contemplated, I/we further request and authorize him to do whatever he deems advisable.

I/we understand and acknowledge that Dr. Redmon has fully explained to me the nature and purpose of this procedure, and possible alternative methods of treatment, the probable risk involved and the possibilities of complications. I/we acknowledge that Dr. Redmon has not made any guarantee or assurances as to the results that may be obtained. I/we understand that persons engaged in learning various phases of medical and related sciences may be present to learn in all phases of the patient’s care and I/we authorize the instruction and teaching of such persons and their direct participation in the patient’s care when Dr. Redmon desires. I/we consent to the disposal of any tissues, fluids or parts of the patient’s body which may be removed, and to the use of such tissue and organs for teaching or research.

I/we further authorize the taking and reproduction of photographs and/or videotapes during the procedure and to use such photographs and/or videotapes for purposes that include, but are not limited to, scientific research, treatment, education and teaching.

I/we have read and fully understand this consent, and the explanations referred to in the consent were made.

Patient Name ____________________________

Parent/Patient/Legal Representative Signature ____________________________

Robert Redmon, MD FACS ____________________________

Date ____________________________