Kass Center For Cosmetic Facial & Eye Plastic Surgery

Specializing in Cosmetic and Reconstructive Surgery of the Face and Eyes

# Lawrence G. Kass, M.D., F.A.A.C.S.

*Diplomate, American Board of Cosmetic Surgery*
*Diplomate, American Board of Ophthalmology*
*Fellow, American Society of Ophthalmic Plastic & Reconstructive Surgery*
*Fellow, American Academy of Cosmetic Surgery*

## CARETAKER CONSENT FORM

*Your post-operative care is critical. Once you leave our office, your care will no longer be in our control. Therefore, you must have someone watching you carefully who can provide you with the correct post-operative care the doctor has prescribed and on which the results of your surgery depend. Ideally, you would have 24-hour nursing care from a qualified nursing center, If instead you choose to have a family member or friend watch over you, then you must ensure that the person you select is qualified to take care of you during this critical state. Failure to have proper post-operative care may result in slowing your recovery, permanent damage and even death. Do not take the appointment of your caretaker lightly.*

*We reserve the right to delay or cancel your surgery if we deem that your caretaker is not of sufficient status to care for you in the first 24 hours.*

### FOR PATIENT TO SIGN

I _____ (full name) appoint _____(full name) as my post-operative caretaker for my surgery on _____(date). I understand the doctor recommends that I have 24-hour nursing care, but I choose this person as my caretaker and accept the risk of my decision. I also understand that my private medical information will be disclosed to my caretaker as needed to help with my recovery. I also understand that any failure on the part of my caretaker does not create a liability to the Kass Center For Cosmetic Facial & Eye Plastic Surgery, or to Lawrence G. Kass, MD., as they are not responsible for my choice in caretaker and his/her abilities. I remain solely responsible for my decision.

Patient Signature: _____ Date:_____

### FOR CARETAKER TO SIGN

I _____ (full name) agree to care for _____ (patient's name) during the post-operative period of 24 hours or more as necessary after surgery on _____ (date). I do not take this obligation lightly. I will keep the patient's medical information confidential and will not disclose said information to anyone except those people involved in patient's care. I agree to monitor the patient carefully by:

- Staying in the same room as the patient
- Making sure breathing is strong
- Assists the patient when using the restroom as needed
- Preventing trips and falls should patient need to walk to restroom
- Giving liquids and food as directed
- Giving the proper doses of medicine and recording patient's response
- Making sure patient's bandages remain secure, clean, and dry
- Provide a working phone number and be willing to accept phone calls from the doctor's office and contacting the doctor if questions or concerns arise

All of these measures should be done through the night. If I have any question at all, I will call the doctor at 727.522.3223 or other numbers supplied to me. If there is any problem, I will immediately call the doctor at 727.522.3223 or other numbers supplied to me.

I also understand that signing this form does not create a relationship between myself and the Kass Center For Cosmetic Facial & Eye Plastic Surgery. Instead, my sole relationship is with the patient, who has chosen me to be the caretaker. Any failure on my part does not make The Kass Center liable in any way.

Caretaker Signature: _____ Date: _____
Phone Numbers to contact Caretaker: _____

American Society of Ophthalmic Plastic & Reconstructive Surgery
Oculofacial Plastic Surgery

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American Academy of Cosmetic Surgery