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PHYSICIAN'S SURGERY & PROCEDURE CONSENT FORM

Date: _____ Time: _____ am/pm

1. I consent to the performance of the following operation or procedure

(Technical name): _____

upon _____
(myself or name of patient)

The purpose of this operation or procedure is (lay language): _____

and will be performed by _____ and whomever (s)he may designate
as assistants.

2. The nature and purpose of the operation or procedure, the benefits and risks of the operation or procedure, the possibilities of complications and the alternatives to this operation or procedure, their risks and benefits have been explained to me.
3. It has been explained to me that a satisfactory result is expected, but that the following are some of the complications or effects that could or may occur: bleeding, infection, damage to adjacent tissues or organs, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence, additional operations, and in rare instances paralysis or death; other: _____

4. No guarantee or assurance has been given by anyone about the results that may be obtained.
5. I consent to the doctors performing whatever different or additional operations or procedures they deem necessary or advisable during the course of the operation or procedure.
6. I consent to administration of such anesthetics as may be considered necessary or advisable for this operation or procedure.
7. I do not have allergies or intolerance to anything except _____.

I have read and understand the content of this form and have received a copy.

Witness to signing

Patient, parent or person authorized to sign for patient (please print)

Physician's signature

Signature of patient, parent or person authorized to sign for patient