

SURGICAL CONSENT FORM

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I hereby consent to the following described medical procedures upon me by or under the direction of Dr. _____, his associates and assistants: _____

In the event that Dr. _____ becomes unavailable, I authorize him to select a replacement to accomplish the agreed to procedures without delay.

I acknowledge that the following information has been provided to me:

Nature of my illness: _____

Purpose of the procedure: _____

Alternative forms of therapy: _____

Risks of the recommended procedure: _____

Risks of the alternative procedures: _____

Risks of not undergoing therapy for my illness: _____

I understand that it will be necessary to receive anesthesia. I further understand that the surgeon(s) will be occupied solely with the surgery and that the administration and maintenance of the anesthesia is an independent function and will be under the direction of _____, an anesthesiologist/nurse anesthetist. I authorize the anesthesiologist/nurse anesthetist to select and utilize the methods and medication he /she feels are most appropriate under the circumstances with the exception of _____. I acknowledge that the anesthesiologist/nurse anesthetist has fully explained the nature of the anesthesia he/she intends to use, alternatives, and the risks of each.

I consent to the admission of observers into the procedure for the purpose of medical education or science.

I further agree that photographs and a narrative of my case may be utilized for medical education or science, including publication in professional journals and medical books. However, any publication of these photographs or narrative will exclude my name so as to protect my identity.

I consent to the performance of operations and procedures in addition to or different from those now contemplated that the above-mentioned doctor, or his associates and assistants, considered therapeutically necessary even though this procedure may not be an emergency. I understand that the extension of this procedure may include risks not previously discussed but, nevertheless, grant to the above-named physician or his associates and assistants, the authority to proceed with such additional procedures.

I further consent to the disposal of tissue or parts removed at the time of the operation.

I understand there can be no guarantee of outcome with any medical procedure and acknowledge that no guarantee has been made to me with regard to these procedures.

I further acknowledge that I have been given full opportunity to discuss the matter contained herein with Dr. _____ and _____ (anesthesiologist/nurse anesthetist) and their associates, assistants, or replacements and that I understand the information provided.

Patient or person authorized to consent for patient: _____

Witness: _____

Date: _____