

**HEALTHCARE  
CONSENT TO SURGERY  
OR OTHER PROCEDURE**



Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

1. I hereby give my consent and authorize Dr. \_\_\_\_\_, and other physicians he may designate as his assistants, to perform the following procedures, \_\_\_\_\_

In the event that Dr. \_\_\_\_\_ becomes unavailable, I authorize him to select a replacement to accomplish the agreed to procedure(s) without delay.

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

Benefits of the procedure: \_\_\_\_\_

Risks of this procedure include pain, infection, bleeding (including severe bleeding that requires a blood transfusion), and may also include heart attack or stroke, allergic reactions, and pneumonia. These are not all the possible risks of this procedure, but these risks can be serious and possibly fatal. Other significant risks of this procedure include: \_\_\_\_\_

Alternatives to the procedure include: \_\_\_\_\_

Risks of the alternative procedures: \_\_\_\_\_

Risks of not having this procedure: \_\_\_\_\_

3. I understand there can be no guarantee of outcome with any surgical or medical procedure, and I acknowledge that no guarantee has been made to me with regard to the results this procedure.

4. I consent to the performance of procedures in addition to or different from those listed above that, in his judgment, my doctor deems medically necessary if any unforeseen conditions arise. I understand that such procedures may include risks not previously discussed.

5. I consent to the disposal of tissue or parts removed during the procedure.

**IF APPLICABLE, patient and physician initial the item(s) below:**

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

\_\_\_/\_\_\_ I acknowledge that my doctor has explained to me that, as an unintended side-effect, I may become sterile as a result of this procedure, and therefore unable to conceive or bear a child.

I acknowledge that I have been given full opportunity to discuss the above matters, my questions have been answered to my satisfaction, and I understand the information provided.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature

If patient is unable to sign or a minor, Person Authorized to sign for Patient: \_\_\_\_\_  
Signature

Relationship to Patient: \_\_\_\_\_ Reason: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Physician receiving Consent: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature