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CONSENT TO SURGICAL AND DIAGNOSTIC PROCEDURES

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENT

DATE: ________________________ ACCOUNT NUMBER: ________________

PATIENT NAME: ____ DATE OF BIRTH: _______________

I, the undersigned, hereby authorize ____ to administer such
(DR NAME)

treatment as is necessary, and to perform the following operation:

____

(Name of Operation and/or Procedure)

I also understand that before consenting to this procedure, I am entitled to be informed, in general terms, of the following:

1. Diagnosis of my condition requiring the procedure
2. The nature and purpose of the procedure
3. The material risks associated with the procedure
4. The likelihood of success
5. The practical alternatives to the procedure
6. The prognosis of my condition if the procedure is rejected by me

____________I have been fully informed by my physician of the matters described above and have had full opportunity to have him answer all my questions.

____________I do not want to be fully informed to the above matters and request that the information not be disclosed.

____________I have not been adequately informed and need to talk to my physician. (If this is checked, Do Not sign this form!)

I, therefore, consent to the procedure, and request that my physician, and any physician designated or selected by him, perform the procedure described above.

I certify that no guarantee or assurance has been made as to the results that may be obtained.

I understand that during the procedure described above, the physician may become aware of conditions which were not apparent at the time this consent was given. I therefore consent to additional or different procedure(s) which the physician considers necessary or appropriate to treat, cure or diagnose such conditions.

I consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedure(s) described above.

I also consent to the administration of such anesthetics as are necessary.

Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practice.

I have been given ample opportunity to ask questions and said questions have been answered or explained in a satisfactory manner.

By signing below, I acknowledge I have read or had this form read or explained to me and I understand it.

Patient Signature: ___________________________________ Witness: ___________________________

Legal Guardian Signature: _________________________________ Witness: ________________________
(Or Nearest Relative)

Authorization must be signed by the patient, or by the nearest relative in the case of a minor; or when a patient is physically or mentally incompetent.

____ ________________________
Physician Signature Date