

CONSENT FOR SURGERY / PROCEDURE OR TREATMENT

1. I hereby authorize _____ and such assistants as may be selected to perform the following procedure or treatment:

I have received the following information sheet:

2. I recognize that during the course of the operation and medical treatment or anaesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above surgeon and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgement necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

3. I consent to the administration of such anaesthetics considered necessary or advisable. I understand that all forms of anaesthesia involves risk and the possibility of complications, injury, and sometimes death.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

5. I consent to the photographing of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

6. I consent to the disposal of any tissue, medical devices or body parts which may be removed.

7. I consent to the utilization of blood products should they be deemed necessary by my surgeon and/or his/her appointees, and I am aware that there are potential significant risks to my health with their utilization.

8. I realize that not having the operation is an option.

9. I AGREE THAT MY SURGERY HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:

- a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
- b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
- c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

Signature of Patient or Person Authorized to Sign for Patient

Printed Name of Patient

Date _____

Signature of operating surgeon