

**INFORMATIONAL USE ONLY**

**CONSENT FOR OPERATION AND ANESTHESIA**

Patient: \_\_\_\_\_

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

1. Operation and Alternatives
  - a. I hereby authorize Dr. \_\_\_\_\_ and whomever he/she designates as his/her assistants to perform the following procedures necessary to treat my condition:  
\_\_\_\_\_
  - b. I understand the reason for the procedure is: \_\_\_\_\_
  - c. Alternatives include: \_\_\_\_\_
  - d. It has been explained to me that conditions may arise during this procedure whereby a different procedure or an additional procedure may need to be performed and I authorize my surgeon and his/her assistants to do what they feel is needed and necessary.
  - e. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.
  - f. I consent to the examination and disposal by my surgeon and/or pathologist of any tissue or body parts which may be removed.
  
2. Risks: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reaction and pneumonia. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include: \_\_\_\_\_  
\_\_\_\_\_
  
3. Anesthesia: The administration of anesthesia also involves risks, most importantly is the risk of reaction to medication's causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services, with the exception of \_\_\_\_\_  
\_\_\_\_\_
  
4. Photography: I consent to the photographing of operations to be performed, including appropriate portions of my body for medical, scientific or educational purposes, providing my identity is not revealed by name in the descriptive texts accompanying them. This may exclude photographs of the face that are recognizable as me.
  
5. Patient's Consent: I have read and fully understand this consent form, and I understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED SURGERY OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED SURGERY OR TREATMENT, ASK NOW, BEFORE SIGNING THIS CONSENT FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

\_\_\_\_\_  
Patient signature (or parent or guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date