



Patient Identification

## Patient Informed Consent

1. **Procedure:** I, \_\_\_\_\_ authorize Dr. \_\_\_\_\_ to perform the following procedure: \_\_\_\_\_

I understand the reason for this procedure is: \_\_\_\_\_

**Alternatives include:** \_\_\_\_\_

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 reactions and pneumonia. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular operation include: \_\_\_\_\_

3. **Drugs and Anesthesia:** The administration of drugs and anesthesia, even local, also involve risks, most importantly, a rare risk of reaction to medications causing death. I consent to the use of drugs and anesthesia as may be considered necessary by the person responsible for these services.

4. **Additional Procedures:** If my doctor discovers a different, unexpected condition at the time of the procedure, I authorize him/her to perform such treatment, as he/she deems necessary.

5. **Blood Transfusion:** In the event of a life threatening event requires the need for blood or blood products as a life saving measure

- I agree to the use of blood products
- I DO NOT agree to the use of blood products

6. **No Guarantee:** 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.

7. **Questions and Answers:** I have read and fully understand this consent form, and understand that 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 consent form.

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

\_\_\_\_\_  
*Patient or person with authority to authorize consent for the patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Time*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Time*

**PHYSICIAN DECLARATION:** I have explained the contents of this document to the patient or guardian and have answered all of their questions. To the best of my knowledge, I feel they have been adequately informed and have consented to the above procedure.

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Time*