

## SURGICAL CONSENT FORM

Patient's Name \_\_\_\_\_

Surgery Date \_\_\_\_\_

1. \_\_\_\_\_ has told me that I have the following condition(s):

2. My doctor recommended the following procedure(s) to treat my condition(s):

3. My condition(s) could also be treated by: \_\_\_\_\_  
\_\_\_\_\_

4. I understand that sometimes during surgery it may be found that additional procedures need to be performed. If I need the additional surgery, I permit the surgeon to perform the necessary procedure(s).

5. My doctor has explained to me that:

A. The procedure(s) to be performed may involve the following RISKS: Possible infection, delayed healing, prolonged pain, scars, loss of blood, loss of toe/foot, reaction to anesthetics, swelling, stiffness, and other possible complications, such as: \_\_\_\_\_  
\_\_\_\_\_

B. There are no guarantees that the above procedure(s) will improve my condition(s).

6. I permit my doctor and/or other doctors chosen by my doctor to perform the above procedure(s).

7. I permit the Hospital/Office to photograph, televise, and/or videotape the procedure(s) on me for educational or research purposes only. My identity is not to be revealed by the pictures on any papers written about them without my permission.

8. I permit qualified persons in the operating room to observe my surgery for educational purposes.

WITNESS: \_\_\_\_\_

PATIENT'S  
SIGNATURE: \_\_\_\_\_

The patient is unable to sign the consent because he/she is a minor.

Age: \_\_\_\_\_ or because: \_\_\_\_\_

PARENT: \_\_\_\_\_

LEGAL GAURDIAN\*: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

\*Legal guardians must possess proof of guardianship and produce it when admitting the patient.

I declare that I have personally explained the above information to the patient or the patient's representative on:

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_