ADVANCE MEDICAL

Home Physicians, PLC

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PHYSICIAN'S SURGERY & PROCEDURE CONSENT FORM

Date: ________________Time: ______________am/pm

1. I consent to the performance of the following operation or procedure
(Technical name): ____
upon____
(myself or name of patient)
The purpose of this operation or procedure is (lay language):____________________________
______________and will be performed by____
and whomever (s)he may designate as assistants.

2. The nature and purpose of the operation or procedure, the benefits and risks of the operation or procedure, the possibilities of complications and the alternatives to this operation or procedure, their risks and benefits have been explained to me.

3. It has been explained to me that a satisfactory result is expected, but that the following are some of the complications or effects that could or may occur: bleeding, infection, damage to adjacent tissues or organs, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence, additional operations, and in rare instances paralysis or death;
other:____
____

4. No guarantee or assurance has been given by anyone about the results that may be obtained.

5. I consent to the doctors performing whatever different or additional operations or procedures they deem necessary or advisable during the course of the operation or procedure.

6. I consent to administration of such anesthetics as may be considered necessary or advisable for this operation or procedure.

7. I do not have allergies or intolerance to anything except______________________________.

I have read and understand the content of this form and have received a copy.

____
Witness to signing

____
Patient, parent or person authorized to sign for patient (please print)

____
Physician's signature

____
Signature of patient, parent or person authorized to sign for patient