



GENERAL CONSENT FOR MEDICAL SERVICES

I hereby request and authorize Dr. _____ and his/her assistants performed the following procedure:

I consent to the performance of the procedure in addition to different from those contemplated or not arising from presently unforeseen conditions, which the above-named doctor or his/her assistants may consider necessary or advisable in the course of the procedure.

I consent to the administration of medications and the performance of other procedures, including, but not limited to the drawing of blood specimens, and the administration of blood transfusions, as the above-named doctor shall deem advisable and necessary. I further request and authorize the above-named doctor and his/her assistants, using the facilities and personnel of the clinic to administer such treatment as is necessary and advisable for my care.

For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.

I consent to the disposal by facility authorities of any tissue or parts of my body, which may be removed.

The nature and purpose of the procedure, the possible alternative methods of treatment, the risks involved in the procedure and the administration of anesthesia, and the possibility of complications have been fully explained to me. I UNDERSTAND THAT THERE IS A RISK OF PERMANENT INJURY AND DEATH ASSOCIATED WITH ALL MEDICAL AND SURGICAL PROCEDURES. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from the procedure.

All blanks or statements in this/her form requiring insertion or completion were filled in, and any items not applicable were crossed or initialed before I signed.

ADDITIONAL RISKS & ALTERNATIVES: _____

I certify I have read or had read to me the contents of this/her form; I understand the risks and alternatives involved in this/her procedure; I have had the opportunity to ask any questions which I had and all my questions have been answered.

Name: _____ DOB: _____

Signatures: _____ Date: _____

Witness: _____ Physician signatures: _____