



CONSENT TO OPERATIVE PROCEDURES

- 1. I hereby authorize Dr. Vikas Merchia and associates...
2. I impose no specific limitations or prohibitions regarding treatment...
3. If any conditions are found at the time of operation...
4. The nature, extent and purpose of the operation...
5. Anesthesia will be given by or under the direction of the Anesthesia Staff.
6. I consent to have the pathologist perform such examination of specimens...
7. I consent to the televising, videotaping and/or photographing of the operation(s)...
8. I consent to the presence of a clinical consultant/observer upon the request/permission of the surgeon.
9. The possible need for a transfusion of blood and/or blood components...
10. Surgeon's comments, if any: Major RISKS including, but not limited to: Bleeding (possibly requiring transfusion); Infection; Injury to surrounding structures (bowel, bladder, nerves, ureter, possibly requiring repair). Failure to obtain desired results. Possible need for further surgery. Possible vascular or respiratory complications, e.g.: blood clots, pneumonia. All surgeries with potential risk of death.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THAT THE SURGEON, OR HIS/HER DESIGNEE HAS ANSWERED ALL OF MY QUESTIONS.

I CERTIFY THAT I HAVE CONVEYED THE RISKS AND BENEFITS OF THE PROCEDURE, AS DESCRIBED BY THE PHYSICIAN, TO THE BEST OF MY ABILITY.

Signature of Surgeon/Designee Date Time

Signature of Translator Date Time

Signature of Patient/Designee Date Time

Witness Date Time

If patient is unable to sign or is under 18 years of age, complete the following:

- Patient is a minor ___ years of age.
Patient is unable to sign because: _____

I am _____ of patient, and hereby consent to the surgical procedure(s) on behalf of the patient: