

Patient: _____

Date: _____ Time: _____

PATIENT CONSENT FORM

1. **Name of Operation or Procedure:** I, _____ (patient or guardian name) give consent for Steven L Porter, MD and any other doctors, associates and assistants, he or she chooses to perform this operation or procedure:

I understand the reason for the operation or procedure is:

Other treatments or procedures the doctor could do instead of this operation or procedure are:

2. **Risk/Dangers:** I understand that any operation or procedure may have risks and dangers that can include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, pneumonia and possible death. Some other risks or dangers of this kind of operation or procedure are:
- _____
3. A doctor or specially trained nurse will give me medicine to keep me from feeling the pain of the surgery. This is called **anesthesia**. The medicine could make me relax or sleep. This medicine could cause problems. I could possibly even die. The doctor or specially trained nurse will decide what medicine to give me. I give my permission for any medicines except for these: _____ (if none, write "none")
4. If my physician finds any unexpected condition at the time of surgery, I give permission for him or her to do whatever treatments or procedures are necessary except I don't want: _____
5. **I understand that no one can promise or guarantee that the operation or procedure will cure me or provide the expected outcome.**
6. I have read and completely understand this consent form. My questions have been answered. I have no more questions.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

Patient Name/Legal Representative

Date

Time

Witness Signature

Date

Time

Physician Declaration: I have explained the contents of this document with the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed. The patient has consented.

Physician Signature

Date

Time