ELEMENTS OF AN INFORMED CONSENT:
(PROCEDURE COMMON AND TECHNICAL NAMES)
(Brief description of the procedure to be performed.)

Patient's
Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in
terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of (procedure name)
have been discussed with me and may include but are not limited to:

• (include common complications/risks)

_____ I understand and accept that there are complications, including the remote risk of death or
serious disability, that exist with any surgical procedure.

_____ I understand and accept the risks of blood transfusion(s) that may be necessary (if applicable).

_____ I understand that tissue cannot heal without scarring and that how one scars is dependent on
individual genetic characteristics. The physician will do his/her best to minimize scarring, but
cannot control its ultimate appearance (if applicable).

_____ I am aware that smoking during the pre- and postoperative periods could increase chances of
complications (if applicable).

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions,
over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or
alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the days
surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to:
estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation. (if
applicable).

_____ Pre- and postoperative photos and/or videos may be taken of the treatment for record
purposes. I understand that these photos and/or videos will be the property of the attending
physician (if applicable).

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ______________________, M.D., with associates or assistants of his or her choice, to perform the
procedure of __________________ on ____________________at______________on the ____________________.
(procedure name) (patient name) (facility name) (right, left, level, body part)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or
advisable should unforeseen circumstances arise during the procedure.

____________________________                 __________________________
Patient or Legal Representative Signature/Date/Time                                    Relationship to Patient

____________________________                 ___________________________
Print Patient or Legal Representative Name                                      Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to
the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient’s legal
representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully
understands what I have explained.

3/03
Revised 9/05, 12/05, 1/06. 3/08

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