

Adult Surgical Consent Agreement

Patient Name:

Date of Birth:

Surgical Procedure:

Date of Surgery:

Surgeon Name:

Consent Statement

I, the undersigned, hereby authorize and consent to the performance of the above-named surgical procedure and any additional procedures deemed medically necessary during the course of the operation by the attending surgeon and/or associates.

I understand and acknowledge:

- The nature and purpose of the operation.
- The possible risks, complications, and expected outcomes.
- The alternatives to the proposed surgery.
- That no guarantee has been made as to the results of the operation or procedures.
- That I have had the opportunity to ask questions and that they have been answered to my satisfaction.

Anesthesia

I recognize that anesthesia is required for this surgery and understand the risks and options were explained by the anesthesiology team.

Blood Transfusion (If Applicable)

I consent / do not consent (circle one) to receive blood or blood products if deemed necessary during my surgery.

Additional Notes/Comments

Patient Signature:

Date:

Witness Name & Signature:

Date:

Surgeon Signature:

Date:

This form is a template and should be reviewed and customized as needed, in accordance with legal requirements and clinical practice.