

Consent Form for Anesthesia and Surgery

Patient Information

Name: _____

Date of Birth: _____

Medical Record Number: _____

Procedure Details

Procedure Name: _____

Date of Procedure: _____

Physician Name: _____

Consent Statement

I hereby authorize the above-named physician and their associates to perform the described procedure and to administer anesthesia, as deemed necessary for my care. I have discussed with my physician the nature and purpose of the procedure, the potential risks and complications, and the available alternatives, including the possible consequences of not undergoing the procedure.

I acknowledge that no guarantee has been made as to the results or outcome. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Patient Declaration

I confirm that I have read and understood this consent form and that I voluntarily give my permission for the procedure and administration of anesthesia.

Signature of Patient / Legal Guardian

Date: _____

Signature of Witness

Date: _____