

## AUTHORIZATION FOR SURGICAL PROCEDURE

NAME: \_\_\_\_\_ ID NUMBER: \_\_\_\_\_ UNIT: \_\_\_\_\_ DATE: \_\_\_\_\_

This individual has the capacity to understand this document as explained to him/her and has the capacity to make the decision regarding consent or refusal of this procedure.  Yes  No (if no, and the individual has no legal guardian, please proceed to the 2 physician consent below).

Physician signature: \_\_\_\_\_ Date & Time: \_\_\_\_\_

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As the patient, you have both the right and obligation to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, BUT IT IS YOUR DECISION WHETHER TO UNDERGO A SURGICAL PROCEDURE.

1. I hereby authorize Dr. \_\_\_\_\_, and whomever he/she may designate as his/her assistants, to perform upon me the following procedure:

\_\_\_\_\_

2. The nature and purpose of the procedure, alternative methods of treatment (including no treatment), the risks and possible complications such as but not limited to POST OPERATIVE INFECTION, DELAYED OR NON-HEALING, PAIN, NUMBNESS, PERSISTENT POST OPERATIVE SWELLING, EXCESSIVE AND/OR PAINFUL SCAR FORMATION, RECURRENCE OF THE CONDITION, AND THE POSSIBLE NEED FOR ADDITIONAL SURGICAL PROCEDURES, have been fully explained to me.

3. I acknowledge that I have received no guarantee concerning the outcome of the surgical procedure to which I am consenting.

4. I consent to the administration of local anesthesia and to the use of such anesthetic agents as he/she may deem advisable.

5. I have informed my practitioner of allergies to the following medications (including anesthetic agents):

\_\_\_\_\_

6. I certify that I have read and fully understood the above consent to procedure, that the explanations therein referred to were made, and that **all blank spaces have either been completed or crossed off prior to my signing.**

\_\_\_\_\_  
Signature of individual

\_\_\_\_\_  
Date & Time:

*If this individual has a legal guardian, consent must be obtained from the guardian.*

\_\_\_\_\_  
Guardian name

\_\_\_\_\_  
Guardian signature

\_\_\_\_\_  
Date & Time

Witness to consent signature of individual or guardian:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date & Time

**Stamp Plate**

Verbal/telephone consent obtained from:

_____ Name	_____ Relationship	_____ Date & Time
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Witness #1 to verbal/telephone consent:

_____ Name	_____ Signature	_____ Date & Time
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Witness #2 to verbal/telephone consent:

_____ Name	_____ Signature	_____ Date & Time
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*If decision making capacity is not present at the time of the consent, 2 physicians must authorize the completion of this procedure as necessary for the health of this individual, with documentation, by each physician, in a progress note of the risk vs benefit of the completion of this procedure.*

_____ Signature of physician #1	_____ Date & Time
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_____ Signature of physician #2	_____ Date & Time
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