

Consent for Surgical Procedure

Date: _____

Patient Name: _____

Date of Birth: _____

Procedure: _____

Physician: _____

Purpose of the Procedure

The purpose of this minimally invasive procedure is to _____.

Description of the Procedure

This procedure involves the following steps: _____.

Benefits and Risks

Benefits of this procedure include: _____.

Potential risks and complications include: _____.

Alternative Treatments

Alternative treatments include: _____.

Patient Statement

I, the undersigned, have read and understand the information provided above. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Signature of Patient: _____

Date: _____

Signature of Witness: _____

Date: _____