

**CONSENT TO OPERATION, PROCEDURE AND
 ADMINISTRATION OF ANESTHESIA**

Dear (Patient) _____,

The purpose of this form is to advise you of important information regarding your operation or procedure recommended by your practitioner. **PLEASE READ THE ENTIRE FORM CAREFULLY BEFORE SIGNING.**

You have been informed about your proposed care, treatment, services, medications, interventions, operation or procedure, and risks, benefits, side effects, potential problems related to the recuperation and the likelihood of achieving your care, treatment and service goals. In addition, you have been informed of any reasonable alternatives to the proposed care, treatment, service or operation and the relevant risks, benefits and side effects related to these alternatives, including the possible results of not receiving care, treatment, or services.

Any operation or procedure may involve the risk of an unsuccessful result of complication, including but not limited to: bleeding, scarring, asymmetry, the need for reoperation, infection, nerve/nervous system damage, injury or even death from both unknown and unforeseen causes.

Name of Practitioner performing procedure: Kimberly P. Cockerham, MD, FACS

Operation of Procedure (Spell out all words, do not abbreviate):

Additional Comment by practitioner (if any):

PATIENT: By my signature below, I confirm that:

1. I have read and understand that information provided on this form, and the operation or procedure and its risks have been explained to me.
2. I have had the opportunity to ask questions and have received all the information I desire about the operation.
3. I understand that in an emergency there may be different or further procedures required if my doctor believes are necessary, and I consent to such procedures.
4. I consent to the performance of the operation or procedure listed about.

 DATE TIME SIGNATURE (Patient, Parent or Property Designated Representative)