PATIENT:_____________________________ DATE/TIME: ________________

Patient Surgery ConsentForm

1. **Name of Operation or Procedure:** I, ______________________________give consent for

Dr. Bailie and his associates/ assistants, he chooses to perform this operation or procedure:

____

____

I understand the reason for the operation or procedure is:

____

AZISKS

______ **Other treatments or procedures the doctor could do instead of this procedure:**

____

2. **Risks|Dangers:** I understand that any operation or procedure may have risks and dangers that can include: infection, bleeding, nerve/blood vessel injury, blood clots, heart attack, allergic reactions, pneumonia, loss of limb, need for further surgery, failure to heal, fracture/dislocation, need for revision surgery, complications relating to implants/hardware/grafts, loss of motion, chronic pain, possiblydeath.

3. A doctor will give me medicine to keep me from feeling the pain of the surgery. This is called **anesthesia**. The medicine could make me relax or sleep. This medicine could cause problems. I could possibly even die. The anesthesiologist will decide what medicine to give me. I give my permission for any medicines except for these (If none, write "none"):

4. If Dr. Bailie finds any unexpected condition at the time of surgery, I give permission for Dr. Bailie to do whatever procedures are necessary except I don't want:

____

IF NOTHING, WRITE "NONE"

5. **I understand that no one can promise or guarantee that the operation or procedure will cure me or provide the expected outcome.**

6. I have read and completely understand this consent form. My questions have been answered. I have no more questions.

Do not sign unless you have read and thoroughly understand this form. By signing this form, I am stating that I have read, understand, consent and agree to the above.

________________________________	__________________
PATIENT / LEGAL REPRESENTATIVE	DATE /TIME (AM|PM)
WITNESS SIGNATURE	DATE /TIME (AM|PM)

PHYSICIAN DECLARATION: I have explained the contents of this document with the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed. The patient has consented.

________________________________ __________________

PHYSICIAN SIGNATURE DATE /TIME (AM|PM)

AZISKS