# Surgical Consent Form

**Purpose:** This document provides essential information regarding the surgical procedure to ensure that the patient understands the nature, risks, alternatives, and benefits associated with the operation. The form must be read, understood, and signed before proceeding with surgery.

## Patient Information

**Full Name:** {fullName}

**Date of Birth:** {dateOfBirth}

**Address:** {address}

**Phone Number:** {phone}

**Emergency Contact:** {emergencyContact}

## Procedure Details

**Procedure Name:** {procedureName}

**Scheduled Date:** {scheduledDate}

**Surgeon:** {surgeonName}

**Description of Procedure:**

{procedureDescription}

## Purpose and Benefits

The purpose of this procedure is to **{procedurePurpose}**. Potential benefits include *{procedureBenefits}*.

## Risks and Complications

The following risks have been explained:

{#risks}

* {risk}

{/risks}

## Alternative Treatments

The patient has been informed of alternative options:

{#alternatives}

* {alternative}

{/alternatives}

## Anesthesia

The patient agrees to receive the following type of anesthesia: **{anesthesiaType}**.

Anesthesia will be administered by: {anesthesiologistName}

## Patient Consent

I, **{fullName}**, confirm that I have had the opportunity to ask questions regarding the surgical procedure, understood the answers provided, and confirm that I have been adequately informed about the procedure.

I voluntarily consent to undergo the procedure named above.

{#hasGuardianConsent}

Guardian Consent:  
As the legal guardian of **{fullName}**, I give full consent for the surgical procedure listed above to be performed.

{/hasGuardianConsent}

{^hasGuardianConsent}

No guardian consent required.

{/hasGuardianConsent}

## Acknowledgments

The following points were reviewed with the patient and/or guardian:

{#acknowledgments}

1. {point}

{/acknowledgments}

## Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** | **Name** | **Relationship** | **Date** |
| {#signatures}{signature} | {name} | {relationship} | {date}{/signatures} |

If you have any questions, please contact our surgical coordination office at {hospitalContact}.