



GENERAL CONSENT FORM

Patient Name:

Surgery Date:

I authorize and direct:

_____ Robi Burns, MD _____ Haydee Docasar, MD

My physician(s) as checked above to perform the following surgical procedure(s) on me:

The risks, indications, benefits and alternative treatment options have been discussed with me. These include but are not limited to the risk of unsuccessful results, excessive bleeding requiring a blood transfusion, damage to adjacent organs including the bladder, ureter(s), bowel, and nerve injury. I am also aware of the risk of injury, death, anesthesia complications and unforeseen causes have also been reviewed. This procedure may also not completely resolve my medical condition.

X _____

Patient Signature

Date _____

X _____

Print Name

X _____

Witness

Relation/title

X _____

Physician Signature

Date _____

*Robi Burns, M.D.*Haydee Docasar, M.D.**