Sample Discussion and Consent for Treatment/Procedure Form

Patient's name: *(Last, First, Middle initial)* _____ Date of birth: _____

I am being provided with this information and consent form so I may better understand the treatment/procedure recommended for me. Before beginning treatment/procedure, I wish to be provided with sufficient information, presented in a form that I can understand, to make a well-informed decision regarding my proposed treatment/procedure.

I understand that I may ask any questions I wish, and that it is better to ask them before treatment/procedure begins than to wonder about these issues after treatment/procedure.

Nature of the Recommended Treatment/Procedure

It has been recommended that I have the following treatment/procedure: _____

_____

This recommendation is based upon physical examination(s), diagnostic test results and my doctor's knowledge of my medical history.

My needs and desires have also been taken into consideration. The treatment/procedure is necessary due to _____

_____

The intended benefit(s) resulting from this treatment/procedure is (are): _____

_____

The prognosis, or likelihood of treatment/procedure success, is: _____

_____

Alternative Treatment/Procedure

The treatment/procedure recommended for me was chosen because it is believed to best suit my needs. I understand that alternative methods or treatment/procedure options include: _____

☐ No other reasonable treatment/procedure options exist for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other treatment/procedure that I have heard or thought about, including: _____

Patient's initials

_____

Risks of the Recommended Treatment/Procedure

I understand that no treatment/procedure is completely risk-free and that my provider will take reasonable steps to limit any complications. I am aware that some treatment/procedure effects and complications tend to occur with regularity. These include:_____

_____

_____ I have had an opportunity to ask questions about these and any other risks about which I have heard or thought.

Patient's initials

(continued)

Acknowledgment

I have provided as accurate and complete a medical and personal history as possible, including antibiotics or other medications I am currently taking, as well as those to which I am allergic. I will follow any and all treatment/procedure and post-treatment/procedure instructions as explained to me and will permit the recommended diagnostic procedures.

I realize that notwithstanding the possible complications and risks, my recommended treatment/procedure is necessary. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees, warranties or representations have been made to me concerning the results of the treatment/procedure.

I, _____, have received information about the proposed treatment/procedure. I have discussed my treatment/procedure with _____ (specify provider), and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment/procedure, alternative options and the risks of the recommended treatment/procedure.

My signature below indicates that I understand the risks and wish to proceed with the recommended treatment/procedure.

Signature of patient or guardian: _____ Date: _____

Signature of treating provider: _____ Date: _____

Signature of witness: _____ Date: _____

This sample form is for illustrative purposes only. Your clinical treatments/procedures and risks may be different from those described. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.