Rahil Malik MD, Fellow of American College of Obstetrics and Gynecology

1200 N University Drive, Plantation, Florida, 33322
Tel: 954-791-3090 Fax: 954-791-3166
www.DavieObGyn.com

GENERAL PROCEDURE CONSENT FORM

Date of procedure**

I NAME AND DATE OF BIRTH _____ request Dr **Malik** to perform upon me the procedure: NAME OF PROCEDURE _____

Indication: The utility and benefit of this procedure was discussed with me prior the procedure:

Risks include: bleeding, hematoma, infection, mild/moderate discomfort, scarring, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition.
Benefits may include: achieving a diagnosis and/or alleviating symptoms.
Alternatives include: not doing the procedure, trial of medical treatment, laser treatment, electrical excision

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment. My signature below certifies that:

1. I have read the above authorization and consent and have been provided the opportunity to ask questions.
2. The proposed procedure(s) including their potential benefits and complication or side effects, problems that may occur during recuperation and the likelihood of achieving expected goals have been explained to me.
3. I understand that I have the right to refuse any medical or surgical procedures or treatment.
4. I certify that I have read and fully understand the above consent and have no further questions which I need answered prior to the procedure.

PREGNANCY TEST: **NEGATIVE** _____ **POSITIVE** _____ PT INITIALS _____
TUBAL LIGATION _____ MENOPAUSE _____

NAME AND DATE OF BIRTH
_____ Date of procedure**
Patient Signature Date

_____ Date of procedure**
Witness signature (Medical Assistant) Date

_____ Date of procedure**
Dr **Malik** Signature Date