Siamak Agha-Mohammadi MD PhD FACS
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Plastic Surgery Body Contouring Center
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MEDICAL AND/OR SURGICAL PROCEDURE SPECIAL CONSENT FORM

PATIENT: _____

DATE: _____ TIME: _____ a.m. _____ p.m. _____

1. I permit Dr. Siamak Agha-Mohammadi and/or such assistants as may be selected and supervised by him to treat the following condition(s):

_____

_____

2. I understand that the following surgical, medical and/or diagnostic procedures are planned for me and I consent to and permit these procedure(s):

_____

_____

3. My doctor has helped me understand the nature of my illness or condition, the proposed treatment, other possible forms of treatment.

4. The likely outcome of treatment, and the likely outcome without treatment (including a discussion of the likely medical results of the proposed treatment and its alternatives).

5. Possible problems of recovery.

6. Potential benefits and risks involved with both the proposed treatment and the alternative forms of treatment.

7. I understand that during the course of the surgery or other procedure Dr. Siamak Agha-Mohammadi or his associates my judge it necessary or advisable to perform additional procedures or render additional medical treatment because of conditions that may not be presently foreseeable. I consent to such additional surgery or treatments and procedures.

8. I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for relief and protection from pain during the procedure(s). I realize the anesthesia may have to be changed, possibly without explanation.

9. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me as the result of treatments or examination in the hospital.

10. I state that I have read, have had explained to me, and fully understand this consent for treatment, and I consent to have the procedure(s) carried out as stated.

Date of Consent:_____ _____

(Signature of Patient)

Date:_____ _____

(Witness)

I have explained the nature, purpose and risks/consequences of the above-described surgery or procedure, alternative methods of treatment (including risks of such alternatives,) and the consequences if no treatment is undertaken. I have given no guarantee or assurance as to the result that may be obtained.

Date:_____ _____

(Signature of Physician)

IF PATIENT IS A MINOR OR IS UNABLE TO SIGN FOR ANY REASON COMPLETE THE FOLLOWING:

The patient is unable to sign because:_____

_____

Therefore, I_____being the closet relative of legal guardian of the patient, hereby authorize and consent to all of the foregoing paragraphs on behalf of the patient, and I assume full responsibility for the reliance of the above named physician upon such authorization and consent.

Date:_____ _____

(Relative or Guardian)

Date:_____ _____

(Witness)