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CYST ASPIRATION

PATIENT NAME: _____

1. I hereby authorize Dr. _____ and/or such assistants as may be selected by him to perform the following procedure(s) on:

_____
(name of patient)

2. The nature and purpose of the procedure or treatment, possible methods of treatment, the risks involved and the possibilities of complications have been explained to me by Dr. _____. These risks include: bleeding, infection, and pneumothorax.

3. I recognize that, during the course of the procedure, unforeseen conditions may necessitate additional or different procedures that those set forth in Paragraph 1. I, therefore, further authorize and request that the above named physician perform such procedures as are, in his/her professional judgment, necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted under this Paragraph 3 shall extend to remedying conditions that are not known to the physician at the time the procedure is commenced.

4. I understand that certain elective operative procedures may require transfusions of blood or blood products. If my physician feels it is appropriate for my medical care, he/she may offer me the options of autologous blood and blood products or directed transfusion, transfusion to me of blood from myself or from a specified relative or friend. This does not exclude transfusion of banked blood products from other donors if an urgent need arises.

5. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation, procedures or treatment.

SIGNATURE: _____ RELATIONSHIP: _____

DATE: _____ TIME: _____

WITNESS: _____