



5500 Dr MLK Jr St North ♦ St Petersburg FL 33703  
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## CONSENT TO LIPOSUCTION SURGERY

After reviewing your complete metabolic panel, the result indicated that your hematology is low on WBC, HGB, HCT, MCV, MCH, MCHC, RDW and high on PLT. It indicates that you have anemia. If you have **anemia**, your blood does not carry enough oxygen to the rest of your body. The most common cause of **anemia** is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the red color to blood. It carries oxygen from the lungs to the rest of the body.

All operations and procedures carry the risk of unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

- The nature of the operation or procedure, including other care, treatment or medications;
- Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur during recuperation;
- The likelihood of achieving treatment goals;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
- Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

Your signature on this form you indicates that:

- You have read and understand the information provided in this form;
- Your doctor has adequately explained to you the operation or procedure, along with the risks, benefits, and alternatives.
- You have the chance to ask your doctors questions.
- You have received all of the information you desire concerning the operation or procedure.
- You authorized and consent to the performance of the operation or procedure.
- You agree to get a follow-up blood work done within 2 days from your date of operation.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Physician: \_\_\_\_\_