Consent for Bariatric Surgery

I _____son/daughter/wife of _____resident of _____has chosen to undergo _____ (name of surgery)

by Dr _____at _____ Hospital on _____. I have suffered from _____"Over Weight (Obesity)" & failed to control with repeated various conservative measures. I understand that obesity is a lifestyle disease & will require modification of my life style even after undergoing bariatric surgery for successful outcomes.

Dr _____ team has explained, in detail, different kinds of bariatric surgeries, their pros & cons & associated risks & benefits. I also understand long term commitment required on my behalf specially in terms of regular supplement intake, periodic tests, follow up visits, support group attendance & emergency reporting as required throughout my life.

The associated risks of surgical intervention include, but are not limited to, anesthesia related complications, deep vein thrombosis, pulmonary embolism, bleeding, leak, stricture, nausea, persistent vomiting, dumping syndrome, hernias, obstructions, atelectasis, fistulas & death. The long-term risks may include deficiency related problems associated with irregular or inadequate intake/discontinuation of supplements without consent of bariatric team.

I completely understand that surgery helps reduce quantity of food intake initially, which is expected to increase to avoid excess weight loss. However, depending on the quality of food consumed, for which I am personally responsible, results of surgery in terms of weight loss may vary. I have understood the required qualitative changes in food & liquid intake & am willing to follow them lifelong.

Though surgery helps in control of various diseases like diabetes, blood pressure, polycystic ovarian disease, sleep apnea, abnormal lipids etc, the extent of remission/improvement may vary subject to period of illness, extent of illness & adequate control prior to surgery. I will not hold surgical team responsible for inadequate or partial improvements of associated illnesses.

In the instance of requirement of extended or ICU stay or any medical/surgical complication, I agree to be transferred to a referral/tertiary care institution. I will not hold surgical team or _____ hospital responsible for any discomfort, cost & problems to me, family or well wishers due to this transfer & subsequent care at other hospital/institution.

I understand that the cost of extended stay, care, further treatment or secondary procedures will be borne by me & is not included in the package agreed by us for treatment at _____.

Name of Patient	Name of Witness	Name of Surgeon/Associate
Signature	Signature	Signature
Date	Date	Date