

**MONTGOMERY COLORECTAL SURGERY LLC**

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**CONSENT FOR SURGERY**

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

I have read my consultation notes written about me and given to me by Dr. Joshua Katz.  
I have understand my medical conditions.  
I have been diagnosed with

\_\_\_\_\_

Dr. Katz has recommended I undergo the following treatment:

\_\_\_\_\_

\_\_\_\_ I have been counseled, have read and understand the risks and benefits of this procedure which Dr. Katz has reviewed with me.

\_\_\_\_ I have been given the opportunity to ask questions which have been answered to my satisfaction.

\_\_\_\_ I understand that surgery is not an exact science and that unforeseen events and complications may arise.

\_\_\_\_ I understand that success cannot be guaranteed even under optimal conditions

\_\_\_\_ I understand that the risks of any surgery include but are not limited to bleeding, infection, need for hospitalization and additional treatment, including surgery, and the risks of anesthesia, including but not limited to heart attack, stroke, and death.

I understand specific risks of my procedure to also include:

\_\_\_\_ Loss or compromise of sexual function

\_\_\_\_ Loss of compromise of bladder control

\_\_\_\_ Loss or compromise of bowel control

\_\_\_\_ Need for colostomy or ileostomy

I wish to proceed with the procedure listed above.

\_\_\_\_\_  
Patient Signature and Date

\_\_\_\_\_  
Name of Witness and Date