ROBERT M. WEST, D.O.
2315 Dougherty Ferry Rd Ste 107
St. Louis, MO 63122
(314) 966-7570

CONSENT TO EXAMINATION AND TREATMENT

I HEREBY AUTHORIZE DR. ROBERT WEST AND SUCH ASSOCIATES, TECHNICAL ASSISTANTS, AND OTHER HEALTH CARE PROVIDERS, TO PERFORM PHYSICAL EXAMINATION AND TREATMENT OF MY CONDITION AS RECOMMENDED BY THE PHYSICIAN. I UNDERSTAND THAT BASED ON MY SYMPTOMS AND EXAM FINDINGS, SUCH PROCEDURES MAY INCLUDE, BUT NOT BE LIMITED TO:

□ HEMORRHOID LIGATION/SCLEROSING/ DESTRUCTION BY COAGULATION
□ EXCISION OF EXTERNAL HEMORRHOIDS OR SKIN TAGS
□ DESTRUCTION OF PERI-RECTAL LESIONS VIA EXCISION OR LASER

I CONSENT TO THE ADMINISTRATION OF LOCAL ANESTHETICS AS DEEMED NECESSARY OR ADVISABLE BY THE PHYSICIAN. I ALSO CONSENT TO LABORATORY EXAMINATION AND DISPOSAL OF ANY TISSUE THAT MAY BE REMOVED DURING A PROCEDURE.

THE PROCEDURE, POTENTIAL RISKS, BENEFITS, AND ALTERNATIVE TREATMENTS HAVE BEEN EXPLAINED TO ME, AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND AND ACCEPT THE RISKS AND CONSEQUENCES ASSOCIATED WITH THE PROPOSED PROCEDURE, INCLUDING BUT NOT LIMITED TO: DISCOMFORT, BLEEDING, INFECTION, ALLERGIC REACTION, AND POSSIBLY DEATH.

I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE REGARDING THE RESULTS OF THE PROCEDURE.

I HAVE READ, OR HAVE HAD READ TO ME, THE CONTENTS OF THIS FORM, AND AS SUCH, I BELIEVE THAT I HAVE ADEQUATE KNOWLEDGE UPON WHICH TO GIVE MY CONSENT.

PATIENT SIGNATURE: _____ DATE:_____

GUARDIAN SIGNATURE: _____ DATE:_____

WITNESS: _____ DATE:_____