

**ACKNOWLEDGEMENT OF PROCEDURAL RISKS AND OUTCOMES BY
HEALTHCARE PROXY**

*** For the purpose of this form, The “Healthcare Proxy” should be a person closest to the patient, (i.e: spouse, parent, sibling, friend, significant other, etc.) who is aware of the patients plans for weight loss surgery, the risks and benefits, and commitment for life.

I _____ am aware that my _____
(Name of Healthcare Proxy) (Relationship To Patient)
will be undergoing surgery with Joseph E. Chebli, MD. I have been actively involved in and fully support
_____ decision to undergo obesity surgery.
(Name of Patient)

My _____ has discussed this surgery with me including the risks,
(Relationship to Patient)
benefits, and potential complications.

- I have been fully informed of the nature of obesity surgery.
- I fully understand that the surgery which _____ will undergo, will
(Name of Patient)
require a lifelong commitment on their part, including changes in diet and behavior modification.
- I also understand that obesity surgery involves dangers and risks including, but not limited to, post-operative infection, leaks, death, depression, emotional changes and other physical and psychological changes which are listed on the informed consent for Lap Gastric Bypass, Open Gastric Bypass, Lap Sleeve Gastrectomy or Lap Adjustable Band Surgery, which I have reviewed and understand.
- I understand that as a result of this surgery, the patient may lose a significant amount of weight, changing his/her appearance.

It is with my full knowledge and consent that my _____, undergo obesity surgery.
(Relationship to Patient)

Print Name

Date

Signature

Date