

*Broward Urology Center*

***Robotic Prostatectomy with Bilateral Lymph Node Dissection Consent Form.***

**Consent**

**I discussed and understand the above risks, benefits, and alternatives with the doctor. I had an opportunity to have all questions answered by the doctor.**

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (print) \_\_\_\_\_ Witness \_\_\_\_\_

The procedure stated on this form, including the possible risks, complications, alternative treatments (including non- treatment) and anticipated results, was explained by me to the patient.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_