Model Consent Form

C.r.no./o.p.d.no.

_____

Name _____ sex : _____ age : _____

son/daughter/wife of
_____

address
_____

_____

Informed Consent

Authorisation for Medical Treatment, Administration of Anaesthesia and performance of Surgical Operation and /or Diagnostic/Therapeutic Procedure R.T.

1. I hereby authorise the XYZ Hospital and those the Hospital may designate as staff to perform upon _____
_____ the following medical treatment, surgical operation and /or diagnostic/therapeutic procedures _____

2. It has been explained to me that, during the course of the operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other emergency procedures in addition to or different from those contemplated at the time of initial diagnosis. I, therefore, further authorise the above designated staff to perform such additional surgical or other procedures as they deem necessary or desirable.

3. I consent to the administration of anaesthesia and to use such anaesthetics as may be deemed necessary or desirable, except to the following exceptions :

(indicate exception or 'None')

4. I state that I am/am not suffering from Hypertension/Diabetes/Bleeding disorders/heart diseases or _____.

5. I also state that I am not suffering from any known allergies or drug reactions.

6. I further consent to the administration of such drugs, infusions, plasma or blood transfusions or any other treatment or procedures deemed necessary.

7. The Nature and purpose of the operation and/or procedures, the necessity thereof, the possible alternative methods, treatment, prognosis, the risks involved and the possibility of complications in the investigative procedures/investigations and treatment of my condition/diagnosis have been fully explained to me and I understand the same.

8. I have been given an opportunity to ask all/any questions and I have also been option to ask for any second opinion.

9. I acknowledge that no guarantee and promises has been made to me concerning the result of any procedure/treatment.

10. I consent to the photographing or televising of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

11. For the purpose of advancing medical education, I hereby given consent to the admittance of observers to the operating room.

12. I also give consent to the disposal by hospital authorities of any tissues or parts which may be removed during the course of operative procedure/treatment.

13. I have / do not have any implant / pacemaker in/on my body _____

14. I am / am not pregnant of _____ weeks.

Icertify that the statements made in the above consent letter have been read over and explained to me in my mother tongue and i have fully understood the implications of the above consent and further submit that statements therein referred to were filled in and any inapplicable paragraphs stricken off before i signed/put my thumb impression.

Signature of patient/

Thumb impression :

Date: Name

Signature, name and address of the witnesses :

1. _____ 2. _____

_____ _____

when patient is a minor or unable to affix signature due to mental physical disability.

Signature/Thumb impression of natural guardian/guardian

Name and Relationship with patient

Signature _____

Name _____

Address of witnesses:

1. _____ 2. _____

_____ _____

I confirm that I have explained the nature and effects of the operation/treatment to the person who has signed the above consent from.

Signature of Doctor-in-charge

Name

Designation

Date