



Consent for Procedure

This consent is valid for 6 months from the date of signing.

Part I

1. I, _____ (the Patient), hereby voluntarily give my consent to undergo the following Procedure:

OR

2. I, _____, H.K.ID. _____ (the Father / Mother / Guardian) of _____ (the Patient), hereby voluntarily give my consent for the Patient to undergo the following Procedure:

Name of Procedure (Block Letter and Full Name) _____

to be performed by Dr. _____ (the Doctor) Code: _____ under *

(Please tick in the appropriate box)

General Anaesthesia

Local Anaesthesia

Regional Anaesthesia (Spinal/Epidural/Others)

I.V. Sedation

Monitored Anaesthetic Care

No Anaesthesia

* The type of anaesthesia will be determined by anaesthetist.

Part II

I acknowledge that, before signing this consent form, I have been fully informed about the proposed Procedure, including the following:

1. General nature and the indication for performing the Procedure.
2. Potential general risks of complications and side effects, including but not limited to bleeding, wound infection, chest infection, other infection, heart attack, stroke, blood clot in the leg veins, blood clot travelling to the lungs, and death.
3. Potential specific risks of complications and side effects relevant to the Procedure and the Patient's condition.
4. Other treatment options and consequences of no treatment.
5. Additional and / or consequential treatment(s) or management which may become necessary during or after Procedure including: *(Please tick box if applicable)*

Intensive Care Blood / Blood Product Transfusion Obstetric Interventions

Conversion to Open Procedure from Endoscopy or Laparoscopy

Other treatment or management, if appropriate:

Patient's Label
Patient Name: _____
Hospital No: _____
Adm No/Episode No: _____



Consent for Procedure

Part III

I understand that:-

1. By necessity, medical practitioners other than the Doctor may assist in performing the Procedure;
2. If tissues or organs are removed during the Procedure, photos may be taken before submitted for pathological examination following which they will be disposed of appropriately, or they may be disposed of without such pathological examination;
3. During the Procedure, photos or other recording may be taken which may be used for medical documentation or teaching purposes. For the latter, the Patient's identity will not be disclosed or identifiable; and
4. There is no guarantee that the Patient's condition or prognosis will improve following the Procedure.

Part IV

If the Procedure is for the purpose of my sterilization, I understand that there is a possibility that I may remain fertile after the sterilization procedure.

Part V (Please tick box if this paragraph is applicable)

- I confirm that I have been provided with an information leaflet on the Procedure (copy attached), and that I have reviewed the same, and that I fully understand the contents.
- The following procedure may be carried out by nurse or other healthcare professional:
such as Transfusion of blood product, Chemotherapy Administration and Dialysis therapy.

Name of Patient/Parent/Guardian (Block Letter)	Signature	Date

Verified by Hospital Staff (Name and Rank)	Signature of Verification	Date

Part VI

Doctor's Declaration:

I have explained the nature, risks, benefits of the Procedure and the charges to the Patient / Parent / Guardian and have answered questions raised. To the best of my knowledge the Patient / Parent / Guardian has been adequately informed and has consented, and the details as such had been documented in the Patient's clinical record.

Name of Doctor(s) who participates in the Operation (Block Letter)	Signature of Doctor(s)	Date

Interpreter

I, _____ (Block Letter), H.K.I.D./Passport No. _____
certify that I have truly, distinctly and audibly interpreted the contents of this document into
(language or dialect) _____, to the Patient / Parent / Guardian.

Signature of Interpreter	Date

Patient's Label
Patient Name: _____
Hospital No: _____
Adm No/Episode No: _____