香港浸信會醫院
Hong Kong Baptist Hospital

Consent for Operation/Procedure/Treatment

Part I

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

OR

2. I, _____, H.K.I.D. / Travel Document No. _____ (the Father / Mother / Legal Guardian) of _____ (the Patient), hereby give my consent for the Patient to undergo the following Operation / Procedure / Treatment :

Name of Operation / Procedure / Treatment (Full Name in BLOCK) _____
_____ (the Procedure)
to be performed by Dr. _____ (the Doctor) Code: _____ under

(Please ☑ as appropriate)

☐ No Anaesthesia

☐ The following type of anaesthesia (as according to the final decision made by anaesthetist):

- ☐ General Anaesthesia
- ☐ Regional Anaesthesia (Spinal/Epidural/Others)
- ☐ Monitored Anaesthetic Care
- ☐ Local Anaesthesia
- ☐ I.V. Sedation

Part II

I/We, the undersigned Patient and or Patient's parent or Patient's legal guardian acknowledge that, before signing this consent form, the doctor (who signs this form) has fully explained to me about the proposed Operation / Procedure / Treatment, including:

1. The nature, effect/benefits and the risks/complications of the Operation/Procedure/Treatment.
2. The general risks/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 Operation/Procedure/Treatment and the Patient's condition. They include:

   _____
   _____
   _____
4. Other treatment options and consequences of no treatment.
5. This consent extending to additional and / or consequential treatment(s) or management which may become necessary during or after Operation / Procedure / Treatment including: *(Please ☑ as applicable)*

   ☐ Intensive Care ☐ Blood / Blood Product Transfusion ☐ Obstetric Interventions
   ☐ Conversion to Open Procedure from Minimally Invasive Procedure
   ☐ Other treatment or management, (please specify) if appropriate:

   _____
   _____

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

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Part III

I understand and agree that:-

1. By necessity, medical practitioners other than the Doctor may assist in performing the Operation/Procedure/Treatment;
2. The doctor/The hospital may dispose of tissues or organs removed as a result of the Operation/ Procedure/Treatment (if any) or submit the tissue(s) or organ(s) for pathological examination after photo taken.
3. During the Operation/Procedure/Treatment, 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 Operation/Procedure/Treatment.
5. If I have any further questions, I can ask the Doctor; and I have the right to withdraw my consent at anytime after I have signed this form but such withdrawal of consent will not invalidate any operation/procedure/treatment performed before such withdrawal is conveyed to the Hospital or Doctor.

Part IV (*Please* ☑ *if this paragraph is applicable)*

☐ I confirm that the following information (Operation/Procedure/Treatment) has been provided to me (_____), and that I have reviewed the same, and I fully understand the contents.

_____	_____	_____
Name of Patient/Parent/Legal Guardian (Name in BLOCK)	Signature	Date

_____	_____	_____	_____
Witness (Name)	Relationship	Signature	Date

Part V

Doctor's Declaration:

I have explained the nature, risks, benefits of the Operation/Procedure/Treatment and the charges to the Patient / Parent / Legal Guardian and have answered questions raised. To the best of my knowledge the Patient / Parent / Legal 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 (Name in BLOCK)	Signature of Doctor(s)	Date

Interpreter

I, _____(Name in BLOCK), H.K.I.D./ Travel Document No._____ certify that I have truly, distinctly and audibly interpreted the contents of this document in (language or dialect) _____, to the Patient / Parent / Legal Guardian.

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

_____	_____
Signature of Interpreter	Date