Ministry of Health and Quality of Life

Consent Form for Surgical Operations and Procedures

Name of Health Institution :..

Patient's Details

Surname: .... **Name**: ....

Unit No. .... N.I.C Number: | | | | | | | | | | | | | | |

Any special needs of the patient (e.g. help with communication)? ....

....

Name of proposed procedure or course of treatment (include brief explanation if medical term is not clear)

....

....

Patient's side*: ☐ left ☐ right ☐ both sides ☐ not applicable

Statement of Health Professional (details of treatment, risks and benefits).

I have explained the procedure to the patient. In particular, I have explained:

(a) the intended benefits of the procedure

....

....

(b) the possible risk/s involved

....

....

(c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatment (including no treatment) and any particular concerns of the patient

....

....

(d) any extra procedures that might become necessary during the procedure such as blood transfusion, other unexpected procedure, etc.,

....

....

The following additional information have been provided

....

....

Signature of Health Professional : .... Date:.....................................

Name and Grade of Health Professional : ....

Please turn over

Consent to Anaesthesia *(to be filled by Anaesthetist)*

I hereby consent for any type of anaesthesia which may be required to enable the treatment/procedure after the following risks and consequences have been explained by a health professional to me/the responsible party/legal guardian*.

☐ Lips/teeth/tongue may be injured ☐ Allergic, anaphylactic reaction to drug ☐ Possible cardiac arrest

☐ High risk case due to associated co-morbidity/surgery itself ☐ Prognosis has been spelt out

Thumbprint

Additional comments ....

....

Signature/Thumbprint* (Patient): .... Date: ....

Signature (responsible party/legal guardian*): .... Date: ....

Signature of Health Professional: .... Date: ....

Name and Grade of Health Professional: ....

Consent of patient/responsible party/legal guardian*

I **confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Thumbprint

I agree to the procedure or treatment.

Signature/Thumbprint* (Patient): ....

Name of patient (in own handwriting): .... Date: ....

Applicable for children, young persons or disabled persons who cannot give consent.

I confirm that I, Mr/Mrs/Miss* ...., am the responsible party/legal guardian* of the above-named patient.

Signature: .... Date: ....

Relationship to patient: .... N.I.C No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Signature (Witness): .... Date: ....

Name of witness (in own handwriting): ....

Address: .... Telephone No. ....

Refusal/Withdrawal of consent

(also applicable to patients who do not wish to proceed with the treatment/procedure after full explanation has been given by health professional)

The patient has withdrawn consent (ask the patient to sign and date here)

Thumbprint

Signature/Thumbprint (Patient): ....

Signature (Witness): ....

Name of witness (in own handwriting): ....

Signature (Health Professional): .... Date: ....

Name (in own handwriting): .... Job title: ....

Consent expressed on this form is valid for the above-mentioned procedure or course of treatment and for this episode of hospital stay only

---

* *Tick boxes or delete text as appropriate*

1113/04/19-85m