Gleneagles Hospital
HONG KONG
港怡醫院

Consent For Operation / Medical Treatment / Procedure

Name:
Hosp. No:
HKID No:
Sex/Age: DOB:
Doctor:

For Clinic Use
Please fill in or affix out-patient label

Hosp No. : HKID No.:
Case No. :
Name :
DOB : M / F

A. Person(s) Signing This Form (The Signatory)

The patient is named at the top right hand corner of this form.
The signatory signing this form is / are: ***(please tick "☑" as appropriate)***

- ☐ The patient.
- ☐ The parent or guardian of the patient who is a minor (age under 18).
- ☐ The patient's legal guardian appointed under Mental Health Ordinance (MHO) with power to consent to the proposed operation / invasive procedure.

_____ _____
Full Name(s) of Parent or Guardian | HKID Card / Identity Document No of Parent or Guardian

B. Operation / Medical Treatment / Procedure

Name and nature of the operation / medical treatment / procedure for the patient:

_____
_____
_____

C. Any Risks / Complications Associated With An Operation / Medical Treatment / Procedure ***(If applicable)***

_____
_____

D. Local Anaesthesia / Sedation To Be Given By Performing Doctor ***(Please tick "☑" as appropriate)***

☐ No Anaesthesia ☐ Not Applicable (Please refer to 'Consent for Anaesthesia')
☐ Local Anaesthesia ☐ Intravenous Sedation ☐ Others (Please specify): _____

Risks / Complications Associated With Anaesthesia ***(If applicable)***

_____
_____

E. Any Consequential Procedure(s) Which May Become Necessary During / Following The Operation / Medical Treatment / Procedure ***(Please tick "☑" as appropriate)***

☐ Not applicable ☐ Blood Transfusion ☐ Intensive Care
☐ Other Procedure(s) (Please specify): _____

F. Any Additional Treatment That Requires Prior Consent From The Patient Before Proceeding The Procedure / Operation ***(If applicable)***

_____
_____

G. Information Sheet ***(Please tick "☑" if applicable)***

☐ I confirm that I have been provided with an information sheet on the procedure / operation (copy attached), that I have reviewed and fully understand the contents.

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H. Consent To The Operation / Medical Treatment / Procedure

I / We, the undersigned patient / patient's parent(s) or guardian(s) / Patient's legal Guardian appointed under the Mental Health Ordinance (MHO):

1. Consent to undergo / the Patient to undergo the operation / medical treatment / procedure set out above.
2. The doctor / health professional (who signs this Form) has fully explained the indications for, nature, effects, benefits, general / specific risks and complications of the operation / medical treatment / procedure, to me / us which I / we fully understand.
3. The doctor / health professional (who signs this Form) has answered any questions and enquiries raised by me / us which I / we fully understand.
4. Understand other treatment options and their associated outcomes and risks.
5. Consent to undergo / the Patient to undergo such alternative or further operation / medical treatment / procedures that the doctor(s) / health professional(s) may consider necessary or desirable.
6. Understand that although the doctor(s) / health professional(s) will perform the operation / medical treatment / procedure in the Patient's best interest, there is no guarantee of cure or improvement.
7. Understand the possible outcomes of **NOT** having the operation / medical treatment / procedure.
8. Consent to undergo / the Patient to undergo such tests and examinations that the doctor / health professional(s) may consider necessary or desirable.
9. Understand the photographs or video recording may be taken for medical record keeping / teaching or research purpose.
10. Agree that the hospital may dispose of tissue(s) or organ(s) removed as a result of the operation / procedure / medical treatment in any manner when it deems fit.
11. Understand the described / said complications and risks of the operation / procedure / medical treatments are not exhaustive. Rare complications may not be listed.
12. Understand that a doctor(s) / health professional(s) other than the attending doctor may assist in the conduct of the operation / medical treatment / procedure ***(Please specify the name and code of the assisting doctor(s) If applicable)***

    _____
13. Agree that this consent shall remain valid for 180 days from the date it was signed or the duration of one hospital admission even though the above operation / medical treatment / procedure may be re-scheduled from time to time.
14. Understand that, if I / we have any further questions, I / we can ask the doctor / health professional(s); and I / we have the right to withdraw my / our consent at any time after I / we have signed this form.

Signature(s) of Signatory(s)	Signature of Doctor	Signature of Witness ***(if applicable)***
Full Name(s) of Signatory(s)	Full Name of Doctor	Full Name of Witness ***(if applicable)***
Date	Date	Date ***(if applicable)***

This Part To Be Completed By Interpreter ***(Please fill in the below information if applicable)***

I _____ (Full Name of Interpreter), _____ (HKID Card / Identity Document No.) certify that I have truly, distinctly and audibly interpreted the consent of this document into _____ (Language / Dialect Used) to the signatory.

Signature of Interpreter	Date

Note: The witness, if available, should be involved in the whole process, from explanation to signing of this Form.