

Consent For Operation / Medical Treatment / Procedure

Name: _____ Hosp. No: _____ HKID No: _____ Sex/Age: _____ DOB: _____ Doctor: _____	Hosp No. : _____ HKID No.: _____ Case No. : _____ Name : _____ DOB : _____ M / F _____
--	---

For Clinic Use

Please affix out-patient label

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)

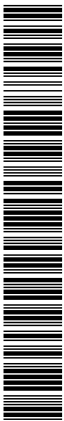
E. Any Consequential Procedure(s) Which May Become Necessary During / Following The Operation / Medical Treatment / Procedure (Please tick "☑" as appropriate)

- 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.



Consent For Operation / Medical Treatment / Procedure

<p>Name: _____</p> <p>Hosp. No: _____</p> <p>HKID No: _____</p> <p>Sex/Age: _____ <i>Please fill in DOB: or</i></p> <p>Doctor: _____ <i>affix out-patient label</i></p>	<p>Hosp No. : _____ HKID No.: _____</p> <p>Case No. : _____</p> <p>Name : _____</p> <p>DOB : _____ M / F</p>
---	--

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 (<i>if applicable</i>)
Full Name(s) of Signatory(s)	Full Name of Doctor	Full Name of Witness (<i>if applicable</i>)
Date	Date	Date (<i>if applicable</i>)

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

I _____, _____ certify that I have truly, distinctly and audibly
Full Name of Interpreter HKID Card / Identity Document No.

interpreted the consent of this document into _____ to the signatory.
Language / Dialect Used

Signature of Interpreter Date

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

