Gleneagles Hospital
HONG KONG
港怡醫院

Consent For Operation / Medical Treatment / Procedure

Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Dr. :	

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

Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Dr. :	

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 *(Ensure patient can accurately read back the operation/procedure name).*

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

Gleneagles Hospital HONG KONG 港怡醫院

Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Dr. :	

Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Dr. :	

For Clinic Use

Please fill in or affix out-patient label

H. Consent To The Operation / Medical Treatment / Procedure

*** (For items 11 and 12, please delete if inappropriate)**

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. 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.
10. Understand the described / said complications and risks of the operation / procedure / medical treatments are not exhaustive. Rare complications may not be listed.

* 11. Understand the photographs or video recording may be taken for medical record keeping / teaching or research purpose.

* 12. 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.

13. 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 of the assisting doctor(s) If applicable)***

_____

I/ We 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.