Consent for Surgical/Invasive Procedure

(1) (A) I, _____ (The Patient), hereby voluntarily give my consent to undergo the procedure of _____, to be performed by Dr. _____ under general/MAC/regional/iv sedation/local/no anaesthesia.

OR

(B) I, _____, the father/mother/Guardian of _____ (The Patient), hereby voluntarily give my consent for the Patient to undergo the procedure of _____, to be performed by DR._____, under general/MAC/regional/iv sedation/local/no anaesthesia.

(2) I acknowledge that, before signing this consent form, I have been fully informed about the proposed Procedure, including the following:

(a) Indication for performing the Procedure.
(b) General nature of the Procedure.
(c) Potential general risks of 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.
(d) Potential specific risks of complications and side effects relevant to the Procedure and the Patient's condition.
(e) Other treatment options, and consequences of no treatment.
(f) Additional and/or consequential treatment(s) or management which may become necessary during or after the Procedure including:
intensive care ☐; blood and or blood product transfusion ☐; conversion to open procedure from minimal invasive procedure ☐. (*please tick box if applicable, and/or insert other treatment or management, if appropriate*)

(3) I understand that

(i) by necessity, medical practitioners other than the Doctor may assist in performing the Procedure;

(ii) if tissues or organs are removed during the Procedure, they may be submitted for pathological examination following which they will be disposed of appropriately, or they may be disposed of without such pathological examination;

(iii) during the Procedure, photographs 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

(iv) there is no guarantee that the Patient's condition or prognosis will improve following the Procedure.

(4) If the procedure is for the purpose of my sterilization, I understand that there is a possibility that I may not remain sterile after the sterilization procedure. (*delete this paragraph, if not applicable*)

(5) I confirm that I have been provided with an information leaflet on the Procedure (copy attached), and that I have reviewed the same, and that I fully understand the contents. (*delete this paragraph, if not applicable*)

_____	_____
Patient/Parent/Guardian's Signature ID/Passport No:_____	Witness of Patient/Parent/Guardian's Name and Signature
Date :	Date :

DOCTOR'S DECLARATION: I have explained the nature, risks and benefits of the operation to the patient and have answered the patient's questions. To the best of my knowledge, the patient has been adequately informed and has consented, and the details as such had been documented in the patient's clinical record.

_____
Doctor's Signature
Date :

I, _____ , certify that I have truly, distinctly and audibly interpreted the contents of this document into (*insert language or dialect*) to the Patient/Parent/Guardian.

_____

Interpreter's Signature
Date :

Endorsed By Hong Kong Private Hospitals Association