

Ahalia



Diabetes Hospital

GENERAL CONSENT FOR TREATMENT

I,.....

(Name & address of the person giving the consent) asking for medical care and medical treatment at Ahalia Diabetes Hospital and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine diabetic care. I understand that these services will be provided to me by Doctors and other health care providers, some of whom may be in training.

I understand that my consent to accept these services will remain in effect unless I say that I no longer require these services or until my treatment is completed.

I understand that my consent to accept these services is termed as General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures as applicable.

Personal Belongings: I assume full responsibility for all items of personal property, including but not limited to, eye glasses, hearing aids, dentures, jewellery, money and all other valuables. I understand that valuables may be secured in hospital safe upon my request and hereby release the hospital of any responsibility for those valuables and items of personal property which are not deposited with the hospital for safe keeping.

Name of Patient/Relative/Guardian:

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

If Guardian/relative, state relationship:

Name of Health care agent:

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

Name of Witness:

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