Ahalia Diabetes Hospital

CONSENT FORM

Name :

Age : ..... Sex : M ☐ F ☐

MR No. :

FOR PROCEDURE / SURGERY, TREATMENT, ANESTHESIA, HIGH RISK CONSENT

(The contents of this form have been explained to me in my spoken language)

Instruction : This consent form should be signed by patient (If an adult 18 years or older) : by a parent / guardian if the patient is a minor: by the spouse or adult children or parents or adult brothers or sisters or other family member or significant other (In this order of priority) if the patient lacks the ability to make an informed decision. The physician or his designee doctors are responsible for obtaining Informed consent.)

1) I hereby authorize Dr. ..... of Ahalia Diabetes Hospital and those whom he may designate as associates or assistants to perform upon, the following medical treatment / surgical operation / diagnostic / therapeutic procedures .....

2) It has been explained to me that during the course of the operation / procedure unforeseen conditions may be revealed or encountered which may necessitate surgical or other procedures In addition to or different from those contemplated. I, therefore, authorize the performance of such additional surgical/other procedures also as deemed necessary / desirable.

3) The nature and purpose of operation / procedure, the necessity thereof, possible alternate options, risks involved, possibility of complications and the prognosis, have been explained to me In the language that I understand.

4) I acknowledge that no guarantee and promises has been made to me concerning the result of any procedure / treatment.

5) I agree to remit the charges of any such surgery / procedure performed, according to the hospital rules.

6) I consent to the administration of such drugs, IV infusions, or any other treatment / procedure as deemed necessary in the best judgment of the treating doctors.

7) I have been explained the possibility of blood loss and I agree to have blood transfusion as and when required.

8) Any tissues or parts removed from my body during the course of operation may be disposed off by the hospital authorities as per the rules.

9) I consent to the photographing or video recording of the operation or procedure, including appropriate portions of my body for educational and research purposes, provided my identity is not revealed by pictures / descriptive texts / any other manner.

10) For the purpose of advancing medical education, I hereby give consent to the admittance observers to the operating room.

11) I have been given an opportunity to ask all / any questions and I have also been given option to ask for any second opinion.

12) It has been explained to me that the risk of operation in my case is high because of I am suffering from Hypertension / Diabetes / Bleeding disorders / Heart diseases or ..... and I am prepared to accept the risk involved and authorize the operation / procedure to be carried out.

13) I also state that I am not suffering from any other known allergies or drug reactions, other than those listed herewith; .....

14) I certify that the statements made above have been read over and explained to me in the language I understand and, have fully understood the Implications of the above consent. I further state that all Insertions / deletions In the above paragraphs were made before I signed / affixed my thumb Impression on this consent form.

Photography : I consent to the photography or televising of the procedure (s) to be performed for the purpose of advancing medical education, or its publication in scientific journals providing my / the patient identity is not revealed by the pictures or description in the accompanying texts. In an effort to further medical science and education. I consent to and authorize the presence of and observation of this procedure by qualified observers as may be authorized Ahalia Diabetes Hospital, Palakkad and its regulatory laws and agencies.

AUTHORIZATION OF PATIENT

I acknowledge that I have had an opportunity to discuss and understand this procedure, as stated above, with my physician or physician designee, and hereby consent to this procedure.

Patient ..... Date .....

Witness ..... Date .....

Doctor ..... Date .....

PATIENT REPRESENTATIVE / SURROGATE

The patient is unable of consent because : ..... and I

..... (name / relationship to the patient), therefore consent for the patient I acknowledge that i have had an opportunity to discuss and understand this procedure, as stated above, with my Physician or physician designee, and hereby consent to this procedure.

Patient ..... Date .....

Witness ..... Date .....

Doctor ..... Date .....

HIGH RISK CONSENT - INDEMNITY STATEMENT

I ..... have been explained about the surgery, I have been explained by the doctors that the causes of my / my patient being High Risk are due to following:

1).

2).

3).

I have also been explained that the possible complications of surgery / anaesthesia are as follows

1).

2).

3).

I also state that I or my family shall not hold Ahalia Hospital or its doctors for any consequences whatsoever.

Patient ..... Date .....

Witness ..... Date .....

Doctor ..... Date .....

Procedure Record

Date : ..... Time : .....

Procedure Planned : .....

.....

☐ Hands washed for 2 minutes prior to beginning procedure

☐ Maximum barrier precautions required during procedure

Pre-Procedure

Physician / Practitioner :

BP: Pulse : Resp : 02 Saturation : IV size, site, condition :

Patient Allergies : .....

Tetanus Prophylaxis : .....

Test Dose : .....

Time out Before Procedure

Correct Patient

Correct Site and Side

Agreement on Procedure

Correct patient position

Availability of correct implants / special equipment

Verification of site markings ( )

Preparation of the Site

Time out participants :

Surgeon / Physician :

Anaesthetist :

Nurse :

Technician :

Others :

Completed by : ..... Sign : ..... Date & Time : .....

Procedure Start Time :	Procedure Stop / End Time :
Record & Notes	

Signature of Doctor : ..... Date & Time : .....

CONSENT FOR ANESTHESIA / ANALGESIA / SEDATION

I consent to the use of anesthesia by my anesthetist and his / her assistants. I understand that the use of anesthetic or placement of intra - vascular lines for invasive monitoring may, despite all appropriate measures to prevent pose certain risks including but not limited to temporary impairment of judgment and motor co-ordination, temporary decrease in attention span : nausea or vomiting : headache; sore throat; muscle aches: bruises or tenderness at the site or intravenous infusions; and may result in paralysis, cardiac arrest or brain damage. In this regard. I have been fully informed, in a language that I understand, the nature and the purpose of the anesthesia, the possible risks and complications, and possible alternative methods, and I understand the explanation, I have received. Furthermore, I have been specifically advised that there is a possibility of damage explanation, I have received. Furthermore, I have been specifically advised that there is a possibility of damage to my / the patient's teeth during the procedure (s) and administration of anesthesia, particularly if the teeth are loose, weak, decayed or artificial, and I hereby waive any claim to damage to my / the patient's teeth as a result therefore.

AUTHORIZATION OF PATIENT

I acknowledge that I have had an opportunity to discuss this procedure, as stated above, with my anesthetist or his / her designess, and hereby consent to the use of the anesthesia discussed.

Patient ..... Date .....

Witness ..... Date .....

Doctor ..... Date .....

PATIENT REPRESENTATIVE / SURROGATE

The patient is unable of consent because : .....and

I. ..... (name / relationship to the patient),

therefore consent for the patient I aknowledge that I have had an opportunity to discuss this procedure, as stated above, with my anesthetist or his / her designee, and hereby consent to the use of the anesthesia discussed.