香港中文大學醫院 CUHK Medical Centre

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CONSENT FOR OPERATION/INTERVENTIONAL PROCEDURE

Please ☑ the appropriate items(s)

The Patient is named in the top right corner of this Form.
The person(s) signing this Form is/are:

☐ the Patient.
☐ the Parent or Guardian of the Patient who is a minor. Name in Block Letters: ____________________

Relationship: ____________ ID No.: ____________

I hereby voluntarily give my consent for myself/the Patient to undergo the operation/ interventional procedure of

____

____________________________ to be performed by Dr. ____________________ , under

☐ General Anaesthesia ☐ Local Anaesthesia ☐ Regional Anaesthesia (Spinal/ Epidural)
☐ Monitored Anaesthetic Care ☐ Intravenous Sedation ☐ Possible combination of the above

I/We, the undersigned Patient and/or Patient's Parent or Guardian:

A. fully understand the proposed operation/interventional procedure includes:
1. the Patient's diagnosis/indications for the operation/interventional procedure;
2. the name and nature of the operation/interventional procedure for the Patient;
3. the intended effect/benefits of the operation/interventional procedure;
4. potential general risks of complications and side effects, including but not limited to bleeding; wound infection; chest infection; other infections; coronary/pulmonary/cerebral vascular complications and death;
5. potential specific risks of complications and side effects relevant to the operation/interventional procedure and the Patient's condition;
6. other treatment options (including the option of no treatment and consequences of no treatment) and their risks/complications;
7. additional and or consequential treatment(s) or management which may become necessary during or after the operation/ interventional procedure including intensive care; blood and/blood product transfusion; conversion to open procedure from minimal invasive procedure;
8. there is no guarantee that the Patient's condition or prognosis will improve following the operation/interventional procedure.

B. voluntarily consent:
1. to undergo/consent to the Patient undergoing such alternative or further procedure/treatment or examinations that the doctor(s)/health professional may consider necessary or desirable.
2. that, by necessity, suitably qualified doctor(s)/health professional other than the particular Doctor may assist in performing the operation/interventional procedure;
3. that the hospital may dispose of tissue(s) or organ(s) removed as a result of the operation/interventional procedure in any manner it deems fit. They may be submitted for pathological examination following which they will be dispose of appropriately, or they may be disposed of without such pathological examination;
4. during the operation/interventional 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.

☐ I confirm that I have been provided with Information Sheet on the operation/interventional procedure (copy given), and that I have reviewed the same, and that I fully understand the contents.

Patient's Signature	Parent/Guardian's Signature	Date (dd-mm-yyyy)
Witness Signature	Witness Name (and Staff Rank if applicable)	Date (dd-mm-yyyy)

DOCTOR'S DECLARATION: I have explained the nature, effect/benefits and risks/complications of the operation/interventional procedure to the Patient and/or the Patient's Parent or Guardian and have answered their questions. To the best of my knowledge, the Patient and/or the Patient's Parent or Guardian has been adequately informed and has consented, and the details as such had been documented in the Patient's Clinical Record.

Doctor's Signature	Doctor's Name	Date (dd-mm-yyyy)

Interpreter *(if applicable)* Name: ____________ Language/Dialect: ____________ Signature: ____________ Date: ____________