Patient Name: Aalliya Sharma
MRN: 312164 Sex: Female
DOB: 29/05/1985 Tel. No.: 0521125445

CONSENT FOR MEDICAL OR SURGICAL INTERVENTIONS

I authorize the performance upon _____ the following
(Myself or Name of Patient)

procedure _____.
(Name of Procedure)

Procedure will be performed / led by: _____.
(Name of Physician Surgeon)

A. The following facts have been explained to me:

1. The nature of the condition and the need to treat such condition (Describe patient's condition):

   _____

   _____

2. The potential benefits are:

   _____

   _____

3. Possible alternatives are:

   _____

   _____

4. I have been informed that the procedure carries the following risks:

   _____

   _____

   _____

   _____

I have also been informed that there are other risks such as severe loss of blood, infection, cardiac arrest, etc., that are associated to the performance of any procedure.

B. **CARE TEAM:**
I am aware that the physician will be assisted by a care team which may include: anesthesia providers, nurses, technicians, medical device specialists, and a surgical team.

C. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me concerning results of the operation or procedure.

D. During the course of the procedures, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I therefore authorize and request that the above named hospital, its employees and designees perform such procedures as are necessary and desirable, in exercising their professional judgement. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to the hospital at the time the procedure is commenced.

E. I also consent to the proper disposal by hospital authorities of tissues or body parts which may be removed during the procedure.

F. I consent to the taking of X-ray, fluoroscopic, computerized Tomography, magnetic resonance, and such other imaging as is necessary in the judgment of the medical staff of Al Zahra Hospital Dubai.

G. I agree to have unplanned/emergency transfusion of blood and other blood products that may be necessary along with the above procedure. The risks, benefits and alternatives have been explained to me and all of my questions have been answered to my satisfaction. ***(If transfusion is refused, cross out and sign this section & complete REFUSAL OF TREATMENT form).***

H. **Enrollment in Quality Improvement Program(s):**
I agree to get enrolled in relevant hospital Quality Improvement Program(s).
I agree on the use of my clinical data for quality auditing purposes and quality improvement activities.
I am aware that this authorization will remain valid until I submit a written request to Al Zahra Hospital Dubai to cancel the use of my health information for quality improvement purposes.

I. **Exceptions to my consent are:** _____
(If none, write none)

J. I hereby certify that I fully understand the information given to me and the implications of consenting to the above procedure.

Patient / Legal Praveen: _____ **Date:** _____ **Time:** _____

Witness: _____ **Date:** _____ **Time:** _____

Translator: _____ **Date:** _____ **Time:** _____

Statement: I have explained the contents of this document to the patient/legal representative and have answered all his/her questions, and to the best of my knowledge, I feel that he/she has been adequately informed and has consented.

Physician Stamp & Signature: _____ **Date:** _____