CLEMENTI HOSPITAL

CONSENT FOR OPERATION / PROCEDURE

FOR PATIENTS OF OR ABOVE 21 YEARS OF AGE WHO ARE MEDICALLY FIT TO GIVE PERSONAL CONSENT ONLY.

PART 1 - TO BE FILLED BY PATIENT

Patient's Name: Lee Ho Yin NRIC/Passport No. S9115479G

1. I, Lee Ho Yin (Name of patient), S9115479G

(NRIC/Passport No.) hereby consent to undergo the ~~operation~~/procedure of INSERTION OF RIGHT CHEST DRAIN

(Name of ~~operation~~/ procedure), the nature, effect and purpose of which have been explained to me by Dr Tony Quek (name of doctor). I have further been advised of the risks and complications associated with this operation/ procedure, as well as any reasonable alternative treatments available. I have had the opportunity to ask questions regarding such risks, complications and alternative treatments.

2. I also consent to:

(a) The performance of operation and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above-named doctor or his associates or assistants may consider necessary or advisable in the course of the operation.

(b) The administration of general, local or other forms of anaesthesia for this operation/ procedure.

(c) The use of drugs and medicines as may be deemed advisable or necessary for the said operation / procedure.

(d) Such further or alternative operative measures or procedures as may be found to be necessary during the course of the operation/ procedure.

(e) The transfusion of blood and other blood derived products as may be deemed necessary.

(f) The taking of photographs/videographs for education/academic and research purpose, where my identity will not be revealed, if used.

(g) The use of contrast media as deemed necessary by the performing doctor or associates or assistants. Therefore I have informed my doctor of all allergies I have, including any previous reaction to contrast media.

3. I acknowledge that no assurance has been given to me that the operation/procedure will be performed by any particular medical practitioner.

4. I understand that in the course of the operation/ procedure, body tissues may be removed as part of the surgical procedure. I further understand that not all of the tissues removed may be required for diagnostic purposes, and the remainder which otherwise would be discarded, may prove valuable for medical research, education and study purposes.

5. I *agree / *do not agree to allow the remainder of any tissue removed not required for my medical management, to be used for medical research and education purposes. I understand that only excess tissue that remains after all the necessary medical tests are completed will be used, and no extra tissue will be taken for these purposes.

☑ Not applicable (no tissue removed)

6*. I **do/ do not*** wish to claim _____ (specify the limb). (Only applicable to patient undergoing procedures/ operation involving the removal of limb)

_____ _____

Signature/ Thumb print of patient Date

PART II - TO BE FILLED BY MEDICAL PRACTITIONER

I, Tony Quek (name of medical practitioner) confirm that I have explained to the patient the nature, effect, purpose and risks of the operation/procedure and the contents of this Consent Form.

_____ _____

Signature of medical practitioner Date

Witnessed by:

Julie Choo	RN	IC: S7975920I
Name	Designation	Signature

PART III - TO BE FILLED WHEN EXPLANATION IS GIVEN BY A TRANSLATOR IN LANGUAGE/DIALECT OTHER THAN ENGLISH

BY TRANSLATOR

* I, _____ (name of translator) confirm that I have explained to the patient/ patient's next-of-kin the nature, effect, purpose and risks of the operation/ procedure and the contents of this Consent Form in _____ (language/ dialect).

_____ _____

Signature of translator Date

BY PATIENT/ PATIENT'S NEXT-OF-KIN

* I, _____ (name of patient), confirm that the nature, effect, purpose and risks of the operation/procedure and the contents of this Consent Form were explained to me by _____ (name of translator) in _____ (language /dialect).

_____ _____

Signature/ Thumb print of patient/ patient's next-of-kin Date

PART IV - TO BE FILLED IN THE EVENT OF REVALIDATION (IF APPLICABLE)

I, _____ (name of patient) confirm that Dr _____ (name of medical practitioner) has explained to me that the patient shall need to have the operation which I previously consented to in the above Consent taken on _____ (date, which was postponed) and that all factors/circumstances remain the same as when the Consent was taken. I hereby re-confirm my consent to the operation on the same terms.

Name and signature of medical practitioner	Name and signature/ Thumb print of patient	Name and signature of witness	Date

* Delete where appropriate