

## CONSENT FOR OPERATION/PROCEDURE

I, \_\_\_\_\_ hereby consent to undergo the following procedure  
on \_\_\_\_\_ at \_\_\_\_\_

The nature and effects of which have been explained to me by Dr Sonia Moorthy.

I acknowledge that I have consented to the procedure/treatment as detailed above:

- I understand that the explanation the doctor gave me as to the need and benefits related to procedure/treatment outlined above.
- I understand the procedure/treatment carries some risk and complication may occur.
- I understand additional procedure(s) may be needed if the doctor finds something unexpected.
- I understand I am able to withdraw this consent at any time prior to the commencement of the procedure/treatment.
- I understand blood products/blood transfusion carry some risk and complications may occur, which have been explained to me.
- I consent to the use of **blood products/ blood transfusions, if needed.**

**Yes                  No**

- I consent to **anaesthetics'**, medicines or to other treatments which could be related to this procedure(s)/treatment.

**Yes                  No**

- I authorize the following to be administered as per my preference sheet/pathway.

**Eye drop regime**

**Pre-operative/ Post-operative medication**

### I REQUEST AND CONSENT TO THE PROCEDURE/TREATMENT DESCRIBED ABOVE:

Signature of Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Read and explained to the signatory who stated that everything was understood.

Signature of Surgeon: \_\_\_\_\_ Dr Sonia Moorthy

### PATIENT ADMISSION DETAILS

Procedure Date: \_\_\_\_\_ Operative Time: \_\_\_\_\_ Length of Stay: Day    Inpatient    o'night

Eye: Left    Right    Bilateral    Provider: Dr Sonia Moorthy

Hospital: \*

- Additional Information:

\_\_\_\_\_

# Signature Certificate

Final Audit Report

2024-01-19

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