

ICON HOSPITAL - INFORMED CONSENT FOR ANAESTHESIA

ISO CERTIFIED 9001:2015

Gat No. 163, Tower Line Corner, Talawade Road, Triveninagar, Pune – 62

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Email: iconhospital2016@gmail.com

Patient Details

Patient Name: _____

PRN No.: _____

Age: _____

Sex: _____

IPD No.: _____

Ward: _____

Bed No.: _____

1. INFORMED CONSENT FOR ANAESTHESIA (ENGLISH)

I, the undersigned, acknowledge that Dr. _____ has explained to me that the patient has to undergo a surgical/operative procedure, for which anesthesia is needed so that the doctor can perform the required procedure.

It has been explained to me by an anesthesiologist that **all forms of anesthesia involve some risk and complications**. Although uncommon, anesthetic procedures may be associated with the sore throat, vomiting, backache, or other minor discomforts. Some unexpected complications may arise with anesthesia and can include: - Remote possibility of drug or allergic reactions

- Dental injury
- Infections
- Bleeding
- Drug reactions
- Blood clots
- Nerve injuries
- Temporary loss of limb function
- Paralysis (rare)
- Brain damage
- Heart attack or other complications, which may result in death.

I understand that the type of anesthesia services to be used for my/our patient will be selected by the anesthetist depending on various factors including the patient's physical condition, type of procedure, doctor's preference, and the patient's own wishes.

I hereby give **full consent** and authorize the hospital and anesthetist to provide anesthesia services as deemed necessary. I understand the nature of anesthesia and the associated risks.

I certify that I have read and understood this form, and that the information has been explained to me in my mother tongue. I acknowledge that I have been made aware that anesthesia can cause unexpected complications.

Signature Section (English)

Signature of Patient: _____

Date: / / _____

Signature, Name & Address of Witness:

Signature of Anesthetist: _____

Name of Anesthetist: _____

Date: / / _____

Time: _____

2. ANAESTHESIA CONSENT FORM (MARATHI VERSION)

आमच्या रुग्ण _____ यांना शस्त्रक्रिया आवश्यक आहे.

हि माहिती डॉक्टरांनी दिली आहे, ज्यासाठी भूल देणे आवश्यक आहे. भूल देताना काही जोखीम होऊ शकतात. यामध्ये: - घसा खवखवणे
- उलट्या येणे
- पाठदुखी होणे
- इतर अस्वस्थकर परिणाम होऊ शकतात
- दुर्मीळ प्रसंगी मृत्यू सुध्दा होऊ शकतो

सर्व प्रकारच्या भूल देण्याचे धोके व संपूर्ण माहिती डॉक्टरांनी दिली आहे.

आवश्यकतेनुसार भूल सेवा प्रदान करण्यास मी पूर्ण सहमती देत आहे.

Marathi Signature Block

नाव: _____

नाते: _____

सही: _____

अंगठा: _____

तारीख: _ / _ / __

वेळ: ____

END OF ANAESTHESIA CONSENT FORM