ICON HOSPITAL – CONSENT FOR SURGERY

ISO CERTIFIED 9001:2015
Gat No. 163, Tower Line Corner, Talawade Road, Triveninagar, Pune – 14
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Patient Details

Patient Name: _____
PRN No.: __
Age: _
Sex: _
IPD No.: ___
Ward: __
Bed No.: __

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1. AUTHORIZATION FOR SURGICAL / OPERATIVE PROCEDURE & ANAESTHESIA (ENGLISH)

I, Mr./Ms. _____, hereby authorize **Name of Hospital / Dr.** _____ to perform the following surgical/ operative procedure:

Procedure: _____

I understand that during the course of the procedure, unforeseen conditions may be revealed or encountered requiring additional or emergency procedures which may be different from those initially planned. I therefore authorize Dr. _____ to perform such procedures as deemed necessary.

I consent to anesthesia and understand that the type used will be based on medical needs except for the following exceptions (if any):
Exceptions: _____

I state that I am NOT suffering from Hypertension / Diabetes / Bleeding Disorder / Heart Disease OR:

I also state that I am NOT suffering from any known allergies or drug reactions unless mentioned below:

I further consent to the use of **drugs, infusions, plasma, blood transfusions** or any other necessary treatment as required.

The nature, purpose, risks, possible complications, available alternative methods, and prognosis have been fully explained to me and I understand them.

I have been given the opportunity to ask questions and request a second opinion.

I acknowledge that no guarantee has been made regarding the results of the procedure.

I consent to **photography and videography** for medical, scientific, or educational purposes provided my identity is not revealed.

I understand that all treatment-related documents will be kept in safe custody of the hospital as required by law.

Patient & Witness Signatures (English)

Signature of Patient / Relative: _____

Date: _ **/** _ / _____

Signature, Name & Address of Witness:
1. _____
2. _____

Signature of Doctor / Surgeon: _____

Date: _ **/** _ / __
Time: ____

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2. शस्त्रक्रियेसाठी संमती (MARATHI VERSION)

आमच्या रुग्ण _____ **यांना** _____ साठी अॅडमिट केले आहे.

या रुग्णाला ही शस्त्रक्रिया लागणे आवश्यक आहे. शस्त्रक्रियेदरम्यान गुंतागुंतीची प्रक्रिया होऊ शकते. त्यामध्ये होणारे फायदे व तोटे डॉक्टरांनी सांगितले आहेत. भविष्यातील उपचारांची माहिती देखील दिली आहे.

शस्त्रक्रियेनंतर लागणाऱ्या पुढील उपचारांबद्दलही रुग्णास माहिती देण्यात आली आहे.

असेल त्यामुळं भूल व शस्त्रक्रियामध्ये धोके जास्त आहेत हि माहिती डॉक्टरांनी दिली आहे.

माझ्या वरील शस्त्रक्रिया व भूल उपचारांस पूर्ण संमती आहे.

स्वाक्षरी विभाग (MARATHI)

नाव: ____
नाते: ____

सही: ____
अंगठा: ____
तारीख: _ / _ / __
वेळ: ____

END OF SURGERY CONSENT FORM