Informed Consent For Surgical Act

Patient Name	:	Reshma Siya				Emirates ID	:	784-6478-3648736-8
File No	:	4	DOB	:	1995-05-21	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Opthalmology Doctor	Date	:	2024-02-27

I, the undersignee Reshma Siya with file number 4, agree that the eye surgeon, Opthalmology Doctor perform surgery on my eye (s) or any additional act necessary for my condition under anesthesia or any other type of anesthesia necessary for my safety after consulting the anesthesiologist.

I admit that the doctor has explained to me the nature of the procedure and its possible complications in the near or far future, that he has explained to me the consequences of not undergoing the procedure, and that he discussed with me the possible alternative procedures.

I also admit that he gave me the chance to ask questions and he answered me to the best of his knowledge and expertise within his specialty.

I am fully aware that any medical procedure has its own complications and side effects that may happen during or after the said procedure and that no medical intervention is guaranteed 100%.

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	Witness	Doctor
		
Patient Name Reshma Siya Date 2024-02-27	Witness Name bbnvbnbvn Date 2024-02-27	Doctor Name Opthalmology Doctor - Ophthalmology (Oph45) Date 2024-02-27

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