



Consent for Operation / Invasive Procedure

Visit No.: Dept.:
Name: Sex/Age:
Doc. No.: Adm. Date:
Attn. Dr.:
Patient No.: PN

Page No:

01	02	03	04	05	06	07	08	09
+10	+20	+30	+40	+50	+60	+70	+80	+90

*Please fill in /
affix patient's label*

I. Status of Signatory who gives consent

- The Patient
- The parent or guardian of the Patient who is a minor
- The Patient's legal guardian appointed under Mental Health Ordinance with power to consent to the proposed operation / invasive procedure
- Others (Please specify designation or relationship) _____

*Name of Signatory

HKID Card No. / Passport No.

II Interpreter (if any)

*Name of Interpreter

HKID Card No. / Passport No.

III. Operation / Invasive Procedure

Name or description of operation / invasive procedure for the Patient : _____

IV. Risk and Possible Complication of the Operation / Invasive Procedure

1. Wound bleeding and wound infection
2. Chest Infection or infection elsewhere
3. Heart attack or stroke
4. Clotting may occur in the deep veins of the leg. Clot may break off and go to the lung
5. Death is possible during or after an operation due to severe complications

Others (including rare but serious complications) : _____

Any Consequential Procedure(s) / Treatment(s) / Management(s) Which May Become Necessary During / Following The Operation / Invasive Procedure

- Blood Transfusion Intensive Care Other Procedure (please specify) _____

Any Specific Treatment that The Signatory Does Not Want Without Further Discussion

V. Information Sheet Provided (if any) _____

VI. If the patient decides not to undergo the operation / invasive procedure, the other options and their risks are explained below (Document in Medical Record if necessary)



Consent for Operation / Invasive Procedure

Visit No.: Dept.:
Name: Sex/Age:
Doc. No.: Adm. Date:
Attn. Dr.:
Patient No.: PN

Page No:

01	02	03	04	05	06	07	08	09
+10	+20	+30	+40	+50	+60	+70	+80	+90

Please fill in / affix patient's label

VII. The Consent

I acknowledge that:

- Any information given to the medical team is accurate and true to the best of my knowledge. I understand that any omission or inaccuracy may lead to serious medical complications and affect the accuracy of estimated risks associated with the procedure.
- The doctor has explained my / the patient's medical condition, the proposed procedure, the likely outcome, and the risks of this procedure. I understand the risks of the procedure, including the risks that are specific to me / the patient, and the likely outcome.
- The doctor has explained other relevant treatment options and their associated outcomes and risks.
- The quoted complications / risks of the procedure are not exhaustive. Rare complications may not be listed.
- The doctor has explained my / the patient's likely outcome on **NOT** having the procedure.
- I was able to ask questions and raise concerns with the doctor about my / the patient's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand that a doctor / doctors other than the attending surgeon may assist to conduct the procedure.
The assisting doctor name is _____ (Full Name) and _____ (Doctor's code).
- I understand that if tissues or organs are removed during the procedure, they may be disposed of appropriately by the Hospital and/ or if the tissues or organs require pathological examination, hospital staff may deliver the specimen to the laboratory directly for examination.
- I understand that during the procedure, consequential procedures may have to be performed, especially those that are needed to save life, limb, or organ.
- I understand that photographs or other recording may be taken during the procedure. These may be used for documentation and teaching purposes. (The patient will not be identified in any visual recording except facial surgeries.)
- I understand that although the doctor(s) will perform the procedure in my / the patient's best interest, there is no guarantee of cure or improvement.

On the basis of the above statements, I agree to undergo the operation / invasive procedure OR I agree to the Patient undergoing the operation / invasive procedure described above.

_____	_____	_____
*Name of Signatory	Signature	Date
_____	_____	_____
*Name of Doctor(s) who perform the Procedure	Signature	Date
_____	_____	_____
*Name of Witness	Signature	Date
_____	_____	_____
*Name of Interpreter (if any)	Signature	Date

*In Block Letters