(5)

कर्मचारी राज्य बीमा निगम अस्पताल,पीण्या, बेंगलूरु- 560 022.

EMPLOYEES' STATE INSURANCE CORPORATION HOSPITAL, PEENYA, BENGALURU - 560 022.

(Under Ministry of Labour & Employment, Govt. of India)

CONSENT FORM

Patient's Name : .....
..... aged ..... S/D/W of ..... address .....
..... State, I am admitting myself under the care and supervision of the Dr. ..... for the treatment, without any coercion, or undue influence.

I hereby consent and agree to the administration of all necessary medications, intravenous fluids, interaction and also to subject myself to all necessary investigations as my attending physician advises.

I agree to the administration of ..... (type of anaesthesia) by Dr. ..... for the performance of ..... (procedures) by Dr. ....., and also to alternative operative measures as may be deemed necessary. I have been explained the risks of anaesthesia as well as pre-aesthetic precautions to be taken.

I further say that I have been explained and I have fully understood, the nature and the procedure involved in my treatment, the administration of anaesthesia, the surgical, procedures, administration drugs, investigations, etc. along with the benefits and risks involved, and consequences of non treatment.

I have had an opportunity, to ask all questions regarding my illness/treatment and the same have been satisfactorily answered by the treating doctors. Other alternative methods of treatment with their consequences have also been discussed. No guarantee has been given to me with respect to the results of the treatment.

I also consent to assistants such as the residents, nurses, staff, etc. as my treating doctor deems necessary.

I agree to the disposal by the hospital authority of any tissues that may be removed in the course of my treatment and agree to the publication of my medical details for scientific or educational purposes provided my identity is not revealed.

I agree to being transferred to any other Hospital during any time of the treatment, if it is beneficial for my health.

I further say that I have informed about all my previous illnesses, treatment, allergies, and all other relevant facts. I shall not hold the doctor responsible for the consequences due to the non-disclosure of the facts.

The above has been explained to me in my own language and I have fully understood the same, I am signing this consent by my own free will.

Place :
Date : Signature
Time :

Signature of witness .....

I hereby declare that I have explained in detail regarding the case to the patient and answered all his queries to his satisfaction in a language that he could understood.