



Bharati Vidyapeeth(Deemed to be University)
 DENTAL COLLEGE AND HOSPITAL
 Dept. of Oral & Maxillofacial Surgery
 Dhankawadi. Pune - 411 043.

IPD/OPD No.: _____

Consent No. : _____

Surname : _____ Name _____ Middle Name _____

Under treatment of Dr. : _____

CONSENT FORM

AUTHORISATION AND INFORMED CONSENT FOR PERFORMING OPERATIONS, SURGICAL / MEDICAL PROCEDURES, INVESTIGATION(S), AND ADMINISTRATION OF ANAESTHESIA.

DATE : _____

1) I, _____ the undersigned, authorise Dr. _____ his / her associate(s), designee(s) & such assistant(s) as may be selected by him/her for [] my own/ [] aforementioned patient's treatment of the following condition(s); and to perform operation / surgical or medical procedure(s) / investigation(s) / administration of anaesthesia/ give medication(s) / give therapy/ give blood transfusion(s) connected there of :

Name of the condition: _____

Name of the Procedure: _____

(Medical Description)

2) I acknowledge that I have understood the operation/surgical or medical procedur(s)/ administration of anaesthesia/ medication(s) therapy/ blood transfusion(s), its purpose and nature, risks, possible complications and consequences associated with it and reasonable alternatives.

3) I have been adequately explained the potential risk, possible consequences and complications associated with this operation/surgical or medical procedure (s)/investigation (s)/ administration of anaesthesia / medication (s)/ therapy / blood transfusion (s) & the probability of the proposed being successful. I am aware that instead of the desired benefit of treatment some complication may arise eg., _____

_____ and believe that to avoid such complications, if any, appropriate care shall be taken by the doctors. I acknowledge that no guarantees can be made about the results.

4) I have been explained clearly that any operation/surgical or medical procedure(s)/ investigation(s)/administration of anaesthesia/ medication (s) /therapy/blood transfusion (s) is not totally safe & that it could be a risk to life of an otherwise healthy person also.

5) I consent to the administration of any type anaesthesia by Dr. _____ his / her associate(s), designee (s) and any such assistants as may be selected by him / her.

6) I have also been informed that there may be other risks including but not limited to, excessive bleeding, infection, cardiac arrest, arrhythmia, pulmonary embolism etc. and complications like these can occur suddenly & unexpectedly while undergoing operation / surgical or medical procedure (s) / investigation (s)/ administration of anaesthesia/ medication (s) / therapy / blood transfusion (s)

7) It has been explained to me that during the course of the operation/procedure unforeseen condition (s) maybe revealed that may necessitate an extension of the original procedure (s) than these set forth in paragraph 1. I therefore authorise & request the above named surgeon, his/ her associate (s), designee (s) & / or assistant (s) to perform such surgical procedure (s) as necessary in the exercise of his / her professional judgement. The authority granted in this paragraph shall extend to meeting all conditions that require treatment & are not known at the time the operation is commenced.

8) I authorise the examination by an authorised individual of any tissues, organs including teeth removed during the procedure & the disposal of such tissue/ organ or body parts in accordance with hospital policies including for research purposes. I give my consent to use my extracted teeth/tissues/organs for research study purpose. Anonymization of the patient data will be strictly maintained.

9) I have been explained (space for issues & explanations specific for the procedure if any)

10) I hereby give consent& have no objection to the recording & documentation of any text/graphic/photographic/video material& information obtained during the procedure & for its use, reproduction, display, projection, publication & presentation for the purpose of medical education.

11) I have been explained that technical failures can occur occasionally due to mal function of electronic, electrical & mechanical equipments & instruments in spite of proper maintenance and that this can cause delay in treatment and / or cause complication that necessitates further treatment.

12) The above authorisation and consent has been explained to me in a language I fully understand and that my questions have been fully & clearly answered to my entire satisfaction. I believe that I have gathered adequate knowledge & information upon which to base an informed consent to the proposed operation / surgical or medical procedure (s) I investigation (s) / administration of anaesthesia I medication (s) / therapy / blood transfusion (s).

I certify that I have read/been read & understand the above consent. That the explanations there in referred to were made, that all blanks & statements requiring insertion or completion were filled in before signature & I give consent to the above mentioned proposed operation/ surgical or medical procedure (s) /investigation (s) /administration of anaesthesia /medication (s) /therapy/blood transfusion (s)

If signed by other than the patient Name : _____ Age :Sex : M / F Address : _____ Relationship with patient : _____

Sign./L.H.T.I.
 (Patient or person authorised to sign on behalf of patient)

Signed in presence of

Witness no 1: Sign./L.H.T.I.

Witness No.2: Sign./L.H.T.I.

Name: _____ Age: _____

Name : _____ Age : _____

Address :

Address:



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If signed by other than the patient

Name : _____

Age : Sex : M / F

Address : _____

Relationship with patient : _____

Sign./L.H.T.I.

(Patient or person authorised to sign on behalf of patient)

Signed in presence of

Witness no 1. Sign./L.H.T.I.

Name : _____ Age : _____

Address : _____

Witness No.2 : Sign./L.H.T.I.

Name : _____ Age : _____

Address : _____