



# THE ASSOCIATION OF SURGEONS OF SOUTH AFRICA



*Affiliated to*

THE SOUTH AFRICAN MEDICAL ASSOCIATION  
*Incorporated Association not for gain. Reg No. 05100136108*

## **PATIENTS PROCEDURE ACCEPTANCE AND CONSENT FORM**

**THIS FORM MUST BE COMPLETED PRIOR TO ANY SURGICAL PROCEDURE**

I, \_\_\_\_\_ (Full name of patient/legal guardian), Identity Document or Passport No.: \_\_\_\_\_ the undersigned, being of major age and of sound mind;

1. I acknowledge that Dr \_\_\_\_\_ (Name of medical practitioner) has discussed and explained the following to me;

**(Patient to tick each applicable box)**

**YES NO**

- |                          |                          |    |   |
|--------------------------|--------------------------|----|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. | The diagnosis of my/the patient's condition;  |
| <input type="checkbox"/> | <input type="checkbox"/> | b. | The nature and purpose of the recommended procedure;  |
| <input type="checkbox"/> | <input type="checkbox"/> | c. | The usual or material risks, side-effects and complications of such recommended procedure;  |
| <input type="checkbox"/> | <input type="checkbox"/> | d. | The alternative forms of treatment available;   |
| <input type="checkbox"/> | <input type="checkbox"/> | e. | The usual or material risks, side-effects and complications of such alternative forms of treatment;   |
| <input type="checkbox"/> | <input type="checkbox"/> | f. | The nature and likely consequences of not proceeding with the recommended procedure or the described alternatives;  |
| <input type="checkbox"/> | <input type="checkbox"/> | g. | The type of anaesthetic to be administered (I understand that a more detailed description of the anaesthetic may be requested by me from the anaesthetist). |

2. I further acknowledge that I have been given the opportunity to ask questions regarding the above, that my questions have been answered to my satisfaction.

3. I fully understand the above.

4. I hereby consent to the performance of (**Name of procedure**) \_\_\_\_\_ on \_\_\_\_\_ (**Name of patient**) and of any other procedure that the surgeon may deem necessary intra-operatively, including the administration of blood products.

\_\_\_\_\_  
**Signature of patient/legal guardian**

**Date:** \_\_\_\_\_

**Time:** \_\_\_\_\_

\_\_\_\_\_  
**Print name in capitals & capacity**