

SURGICAL CONSENT FORM

I, the patient (guardian)

ID number / Date of birth (sticker)

hereby consent to the performing of the following surgical procedure on the (encircle): **LEFT / RIGHT**

The surgeon provided me with the general explanation of the nature of this operation and the reasons why it is indicated for my medical condition.

COMPLICATIONS

The doctor discussed the risks and benefits of the operation including any alternative treatment. Serious and common risks related to the proposed surgery include: bleeding, wound complications, infection, blood clots, implant / prosthesis related complications, fractures, reoperation, malunion, non-union etc.

I acknowledge that some of the serious and common complications listed above were discussed and I'm aware that this is not a full list, and other unforeseen adverse events could occur. I also fully understand that all the anaesthetic related complications associated with surgical procedures should be discussed directly with the relevant anaesthetist. I fully understand that the giving of anaesthesia does not fall under the surgeon's area of expertise and hence it is my duty to ask the relevant anaesthetist any questions relating to the anaesthesia and complications associated with anaesthesia.

AUXILIARY CONSENT

I hereby give my informed consent to receive all necessary medical care as determined by my treating physician. This includes, but is not limited to: surgical procedures, diagnostic tests (radiological investigations / laboratory investigations), administration of anaesthesia, administration of blood transfusions or blood products, HIV testing, any other medical intervention that may be deemed necessary for my health and safety. I also understand that, in the event of a healthcare worker sustaining a needle-stick or other exposure injury during my treatment, I may be tested for communicable diseases such as HIV, in accordance with standard safety protocols. I acknowledge that a team of qualified healthcare providers—including physicians, nurses, anesthetists, and other specialists—may be involved in my care, and I extend this authorization to include all such personnel.

Initials:

COST CONSENT

I understand that I am responsible for the fees as explained to me by the doctor, or, if not specifically explained, for the customary fees for any services which may apply. I understand that I may be responsible for co-payments for any orthopaedic prostheses, bone graft substitutes, hospital co-payments or any other expenses that are not covered by my Medical Aid. If the medical aid pays money directly into my account, I will reimburse the doctor in full immediately.

GENERAL

- I do not have the doctors consent to record him / her during consultations or medical / surgical procedures without his consent.
- I confirm that it is my duty as a patient to make arrangements to ensure my follow up appointments are scheduled and confirmed. I understand that the doctor/s will take steps to make this process as easy as possible, however the ownness is on me, the patient, to confirm the necessary arrangements with their rooms.
- I confirm that if I have missed any scheduled follow up appointments that, I the patient, will make alternative arrangements with the rooms for a suitable new follow up date.
- I confirm that I fully understand that the doctor/s rooms are not open after normal working hours and that any communications between myself and the rooms after hours will **not** be answered until ordinary hours resume. This applies to periods when the surgeon/s may be on leave.
- I confirm that I understand that if I, the patient, am experiencing severe pain or illness of any kind, relating to, or unrelating to my condition / surgery, that it is recommended and in my best interest to visit the nearest emergency unit immediately as opposed trying to contact the doctor/s rooms.

POPI AGREEMENT

I confirm that I have read and fully understand the POPI agreement available on www.limbreconstruction.co.za

REPRESENTATIVE CONSENT

I consent to the presence of a company representative in theatre during my surgery if required. It is understood that the company representative advises the theatre staff on the company's medical devices to be used.

MEDIA CONSENT

I consent to the taking of photographs and collecting or using clinical information for clinical / research / registry purposes only. I understand that the doctor will not use these photographs or information in any manner that will identify me.

CONCLUSION

After discussing the above, the surgeon gave me an opportunity to ask questions and seek further information. I do not require further information and I am prepared to consent to him proceeding with the recommended operation. I believe that the doctor has honoured my right to make my own informed healthcare decision. I give my consent voluntarily and freely and certify that I can give valid

Initials:

consent. I understand that I can revoke my consent to the operation at any time up until the time the operation process has started. I also consent to my personal information including information relating to my health and treatment being processed or given to any person if necessary, in relation to the operation and related treatment and payments due.

In the event of allegations of negligence, I agree to embark on mediation prior to embarking on litigation.

Surgeon

Patient / Guardian name + surname

Patient / Guardian signature

Witness name + surname

Witness signature

Date: _____ / _____ / 20

Initials: