

**HOSPITAL AUTHORITY  
CONSENT FOR OPERATION/  
PROCEDURE/TREATMENT  
NOT REQUIRING ANAESTHETIST(S)**

Admission/Clinic No. \_\_\_\_\_ ID No. \_\_\_\_\_  
Name \_\_\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ Chinese Name \_\_\_\_\_  
Dept \_\_\_\_\_ Ward \_\_\_\_\_ Bed \_\_\_\_\_

- Note 1 This Form documents the consent of the Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the Mental Health Ordinance (MHO) vested with power to consent to treatment to proceed with the operation/procedure/treatment that the registered doctor/health professional have proposed. **It is only designed for operation/procedure/treatment where the anaesthetist is not involved in the care, for example for drug therapy where written consent is appropriate.** In other circumstances, the registered doctor/health professional should use "Hospital Authority Consent for Operation/Procedure/Treatment requiring Anaesthetist(s)" form.
- Note 2 For a minor who is under 18 years of age and can understand the contents of this Form and the explanation given, only the minor needs sign this Form. Whenever appropriate, both the minor and the parent or guardian should sign this Form.
- Note 3 For any adult who cannot consent or any mentally incapacitated adult within the meaning of the MHO who cannot consent and who does not have a legal guardian appointed under MHO, the "HOSPITAL AUTHORITY FORM FOR PATIENTS WHO ARE UNABLE TO CONSENT FOR OPERATION/PROCEDURE/TREATMENT" should be used.
- Note 4 This Form should be signed by the registered doctors/health professional who gave the explanation to the Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the MHO vested with power to consent to treatment.
- Note 5 The witness (who can be a staff member or a third party such as the Patient's next-of-kin) should be involved in the whole process – from the explanation giving to the signing of this Form. Please enter 'NIL' in the witness field in the absence of witness.

**A. PERSON(S) SIGNING THIS FORM**

The Patient is named in the right hand top corner of this Form.

The person(s) signing this Form is/are:  
(Please tick as appropriate.)

- ☒ the Patient.
- ☐ the Patient who is a competent minor.
- ☐ the parent or guardian of the Patient who is a minor.
- ☐ the Patient's legal guardian appointed under MHO with power to consent to the proposed operation/procedure/treatment.

Name in Block Letters \_\_\_\_\_

HKID Card / Identity Document No. \_\_\_\_\_

Address \_\_\_\_\_

Phone No. (Day) \_\_\_\_\_ (Night) \_\_\_\_\_

Relationship with the Patient (please tick as appropriate):

- ☐ the parent or guardian of the Patient who is a minor.
- ☐ the Patient's legal guardian appointed under MHO with power to consent to the proposed operation/procedure/treatment.
- ☐ others (please specify) \_\_\_\_\_

The explanation given by the doctor(s)/health professional with the relevant knowledge to the Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the MHO is set out below.

**B. INDICATIONS AND OPERATION/PROCEDURE/TREATMENT**

The Patient's diagnosis/indications:

AVN of 1<sup>st</sup> metatarsal head

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Name or nature of operation/procedure/treatment for the Patient:

Conservative treatment with analgesics and restricted weight bearing

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The intended benefits are:

Relieve symptoms

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**C. ANY EXTRA PROCEDURES WHICH MAY BECOME NECESSARY DURING THE OPERATION/PROCEDURE/TREATMENT**

☐ Blood transfusion.

☐ Other procedure (please specify) \_\_\_\_\_

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Available alternative(s) (including no operation/procedure/treatment):  
(Continue in Medical Records if necessary)

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**ANY SPECIFIC TREATMENT THAT THE PATIENT DOES NOT WANT WITHOUT FURTHER DISCUSSION:**

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**D. STATEMENT OF REGISTERED DOCTOR/HEALTH PROFESSIONAL**

*(To be filled in by a doctor/health professional with the relevant knowledge.)*

I have explained the proposed operation/procedure/treatment to the Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the MHO. In particular, I have explained:

The treatment procedure

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Serious or frequently occurring risks:

Pain, deterioration of disease progression

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Any specific treatments the Patient has expressly declined:

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I have also explained what is likely to be involved, the benefits and risks of any available alternative treatments (including no treatment) as well as any particular concerns:

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**THE FOLLOWING LEAFLET HAS BEEN PROVIDED, IF ANY**



Signature of Doctor/Health Professional  
*See Note 4*

Signature of Witness (if any)  
*See Note 5*

Michael Tim Yun Ong

Name of Doctor/Health Professional  
in Block Letters and Staff Rank

Name of Witness in Block Letters (if any)

11/7/2021

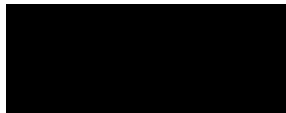
Date

Witness (if any)  
(Staff Rank/Relationship with Patient)

**E. STATEMENT OF PATIENT AND/OR PATIENT'S PARENT OR GUARDIAN/  
PATIENT'S LEGAL GUARDIAN APPOINTED UNDER THE MHO**

I, the undersigned, state that:

1. The doctor/health professional has fully explained the above to me which I fully understand. The doctor/health professional have also answered the questions I have asked. I agree to undergo the operation/procedure/treatment/I agree to the Patient undergoing the operation/procedure/treatment described above.
2. I understand that no assurance can be given by the hospital that the operation/procedure/treatment will be performed by particular health professional(s).
3. I understand that the operation/procedure/treatment may/may not involve local anaesthesia.



11/7/2021

Signature of Patient  
*See Notes 1, 2 & 3*

Date



Michael Tim Yun Ong


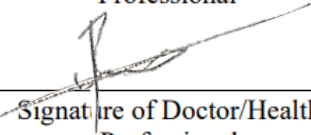
Signature of doctor/health professional

Name of doctor/health professional in block letters and staff rank

**F. CONFIRMATION:**

*(To be completed by a doctor/health professional when the Patient is admitted for the operation/procedure/treatment, and when the Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the MHO has signed the form in advance for more than 6 months.)*

I have confirmed with the Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the MHO who has no further questions and wishes the operation/procedure/treatment to go ahead.

	<b>Michael Tim Yun Ong</b>	<b>11/7/2021</b>
Signature of Doctor/Health Professional	Name of Doctor/Health Professional in Block Letters and Staff Rank	Date
	<b>Ronald Siu Wing Hei</b>	<b>11/7/2021</b>
Signature of Doctor/Health Professional	Name of Doctor/Health Professional in Block Letters and Staff Rank	Date

**IMPORTANT NOTES:** *(Please tick if applicable)*

- ☐ The Patient and/or the Patient's parent or guardian/the Patient's legal guardian appointed under the MHO has withdrawn consent (please ask the Patient and/or Patient's parent or guardian/the Patient's legal guardian appointed under MHO to sign and date here).

Signature of Doctor/Health Professional	Name of Doctor/Health Professional in Block Letters and Staff Rank	Date
Signature of Doctor/Health Professional	Name of Doctor/Health Professional in Block Letters and Staff Rank	Date