Changi General Hospital
SingHealth

CONSENT / ACKNOWLEDGEMENT FOR OPERATION/PROCEDURE

[redacted]

Proposed Operation/Procedure REVISION LUMBAR SPINE TWO TO SACRAL SPINE ONE POSTERIOR DECOMPRESSION AND INSTRUMENTED FUSION

The patient is:
- Of age 21 years & above and is fit to give personal consent. **(Complete Sections A+C)**
- Under 21 years of age. **(Complete Sections A+B+C)**
- Unfit to give personal consent. **(Complete Sections B+C)**

Section A

DECLARATION BY PATIENT (Patients who are fit to give consent (including those under the age of 21)

1) I, [redacted] (Name of Patient),of [redacted] (NRIC/Passport No.), hereby consent to undergo the above-named operation/procedure. The nature, effect and purpose of the above-named operation/procedure have been explained to me. In addition, I have been advised of the benefits, risks, complications associated with this operation/procedure and any alternative/conservative treatment(s) available. I have read and understood the information provided and have had the opportunity to ask questions or raise any specific issues of concern. These details have been explained to me by-

Dr. [redacted] (Name of Doctor).

2) I acknowledge that no assurance has been given to me that the operation/procedure will be performed by any particular medical practitioner.

3) I also consent to the following:

(a) The performance of operations and procedures in addition to the above-named operation/procedure, whether or not arising from presently unforeseen conditions, which the performing doctor may consider necessary in the course of the operation/procedure.

(b) The administration of sedation, general, regional, local or other forms of anaesthesia for this operation/procedure.

(c) The use of drugs and medicines as may be deemed advisable or necessary for this operation/procedure.

Section B

DECLARATION BY PARENT/NEXT-OF-KIN/GUARDIAN* (Patients below 21 years of age OR patients who are unfit to give personal consent)

1) I, _____ (Name of Parent/Next-of-Kin/Guardian*) of _____ (NRIC/Passport No.), hereby acknowledge that the above-named patient will be undergoing/ consent to my child/ward* to undergo the above-named operation/procedure. The nature, effect and purpose of the above-named operation/procedure have been explained to me. In addition, I have been advised of the benefits, risks, complications associated with this operation/procedure and any alternative/conservative treatment(s) available. I have read and understood the information provided and have had the opportunity to ask questions or any specific issue of concern. These details have been explained to me by-

Dr. _____ (Name of Doctor).

2) I acknowledge that no assurance has been given to me that the operation/procedure will be performed by any particular medical practitioner.

3) I also consent to / support the need for* the following:

(a) The performance of operations and procedures in addition to the above-named operation/procedure, whether or not arising from presently unforeseen conditions, which the performing doctor may consider necessary in the course of the operation/procedure.

(b) The administration of sedation, general, regional, local or other forms of anaesthesia for this operation/procedure.

(c) The use of drugs and medicines as may be deemed advisable or necessary for this operation/procedure.

*Delete as appropriate

(d) The transfusion of blood and other blood derived products during and up to 24 hours after the operation/procedure as may be deemed necessary.

(e) The use of contrast media as deemed necessary by the performing doctor. Therefore I have informed the doctor of all allergies that I may have, to the best of my knowledge, including any previous reaction to contrast media.

4) I **do/do not*** wish to claim _____ (specify the tissue/limb removed). [If applicable]

5) I understand that during the procedure, photographs/ videographs may be taken, which may subsequently be reproduced, published, distributed and exhibited for education/academic and/or research purposes. I understand that the photographs/ videographs, if used for such purposes, will not have any features that will lead to my identity being disclosed. If the proposed photographs/ videographs are expected to include any features that can identify me, a separate consent will be taken.

6) Additional information, if any, conveyed to patient:

_____

_____

_____

[redacted] 7/9/2019

Signature of Patient Date

(d) The transfusion of blood and other blood derived products during and up to 24 hours after the operation/procedure as may be deemed necessary.

(e) The use of contrast media as deemed necessary by the performing doctor. Therefore I have informed the doctor of all allergies that the patient may have, to the best of my knowledge, including any previous reaction to contrast media.

4) I **do/do not*** wish to claim _____ (specify the tissue/limb removed). [If applicable]

5) I understand that during the procedure, photographs/ videographs may be taken, which may subsequently be reproduced, published, distributed and exhibited for education/academic and/or research purposes. I understand that the photograph/ videographs, if used for such purposes, will not have any features that will lead to the patient's identity being disclosed. If the proposed photographs/ videographs are expected to include any features that can identify the patient, a separate consent will be taken.

6) Additional information, if any, conveyed to the Parent/Next-of-Kin/Guardian*:

_____

_____

_____

_____ _____ _____

Signature of Parent/Next of kin/ Guardian* Relationship to Patient Date

I understand that in the course of the operation/procedure, body tissues may be removed as part of the procedure. I further understand that not all of the tissues removed may be required for diagnostic purposes, and the remainder which otherwise would be discarded, may prove valuable for medical research, education and study purposes.

I agree to allow the remainder of any body tissue removed not required for medical management, to be used for education/academic and/or research purposes. I understand that only excess tissue that remains after all the necessary medical tests are completed will be used and no extra tissue will be taken for these purposes.

I agree [redacted] Signature of Patient

I understand that in the course of the operation/procedure, body tissues may be removed as part of the procedure. I further understand that not all of the tissues removed may be required for diagnostic purposes, and the remainder which otherwise would be discarded, may prove valuable for medical research, education and study purposes.

I have no objections in allowing the remainder of any body tissue removed not required for medical management, to be used for education/academic and/or research purposes. I understand that only excess tissue that remains after all the necessary medical tests are completed will be used and no extra tissue will be taken for these purposes.

I agree ☐+ _____ Signature of Parent/Next-of-Kin/Guardian*

*Delete as appropriate +Tick where appropriate