Patient Identification:

INFORMED CONSENT FOR OPERATION OR OTHER PROCEDURE

I, _____ ☐Self ☐Son ☐Daughter ☐Wife ☐Guardian ☐Next of Kin of _____, hereby authorize Dr(s). _____ _____ of the Aga Khan University Hospital and/or members who form part of their team to perform upon me/my patient the following operation or procedure:

_____

_____

to treat the following condition(s): _____

_____

1. Dr._____ has discussed with me in detail and has clearly explained to me and I understand:
   a. The nature, purpose and benefits of the proposed operation or procedure and the risks associated with it.
   b. That all operations and procedures carry the risk of unsuccessful results, complication and/or injury from both known and unforeseen causes, and no guarantee has been made that the procedure will improve the condition even though it will be carried out with due professional care.
   c. The likelihood of success, any undesired outcome(s) or adverse reactions, their implications and the risks involved.

   General Complications associated with operations and other invasive procedures include but are not limited to: Bleeding, infection, wound disruption, scarring, injury to surrounding structures and death.

   Specific Complication associated with the operation(s) or procedure(s) recommended above include, but are not limited to:

_____

_____

_____

_____

d. That unanticipated findings during the operation or procedure, or the development of known or unforeseen side effects or complications may prolong hospital admission or require a higher level of care, such as in an Intensive Care Unit.

e. That other reasonable treatment choices and alternatives have been discussed with me. I understand the potential benefits and risks of these other treatment options. I also understand the risks if I elect not to have the operation or procedure.

f. That during the procedure a condition or complication (howsoever remote) may be discovered or may arise, which was not previously apparent. Therefore, I authorize the doctor to perform any additional or different treatment which is thought medically necessary and beneficial in the reasonable judgment of the treating doctor.

g. That any tissue, parts or substances removed during the operation or procedure may be retained or disposed of in accordance with hospital policy and clinical practice.

h. That in the event of an intrauterine death, the Aga Khan University Hospital may suitably dispose of the fetus, unless I give prior written instructions to the contrary.

2. I consent to the use of any and all sedative and anesthetic techniques and agents, other drugs or any other treatment believed necessary during the above-mentioned operation or procedure.
3. I also allow the use of contrast media as deemed necessary by the performing doctor or associates or assistants. I have informed my doctor of all allergies I have, including any previous reaction to contrast media.
4. Video or photographic recording may be done during the procedure. This will either be maintained as part of your / the patient's medical record, or used for educational / academic purposes. If used for educational / academic purposes all identification will be removed from the recorded material.
5. I authorize transfusion of blood products believed necessary during the operation or procedure. I have been explained the risk of receiving and not receiving transfusion.

   ☐ I consent to receive any blood product(s) required

   ☐ I refuse to receive blood products(s)

   ☐ Not applicable

6. I acknowledge that

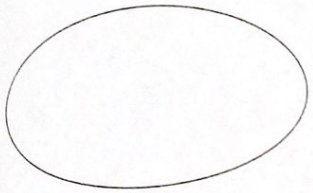
   - the above information, including the risks, benefits and alternatives of the operation / procedure, and any undesired adverse reaction or outcome has been given to me in a language which I understand and is sufficient for me.
   - I have read the contents of this consent form, or it has been read to me.
   - I have had the opportunity to ask questions concerning me/my patient's condition and about the operation or procedure and all questions have been answered to my full satisfaction.
   - I consent to and authorize the operation or procedure described above as necessary and appropriate by my doctor.

Signature of patient مریض کے دستخط

Name of patient مریض کا نام

If the consenting person is unable to sign, affix thumbprint

اگر اجازت کنندہ دستخط نہ کر سکتا ہو تو دی گئی جگہ میں انگوٹھے کا نشان لگائے۔



☐ Left بایاں انگوٹھا ☐ Right دایاں انگوٹھا

If patient is a minor or is unable to give consent due to any medical condition

اگر مریض بچہ ہے یا طبی حالت کی وجہ سے اجازت نہیں دے سکتا۔

Signature of parent/guardian/next of kin
مریض کے والدین یا رشتہ دار کے دستخط

Name of parent/guardian/next of kin
مریض کے والدین یا رشتہ دار کا نام

Relationship دستخط کنندہ کا مریض کے ساتھ رشتہ

Date and time تاریخ: وقت:

Signature of doctor taking the consent
ڈاکٹر کا دستخط جس کی درخواست پر اجازت نامہ دیا جا رہا ہے

Name of doctor taking the consent
ڈاکٹر کا نام جس کی درخواست پر اجازت نامہ دیا جا رہا ہے

Designation عہدہ

Date and time تاریخ: وقت:

Witness 1 گواہ

Signature دستخط:

Name نام:

Date and time تاریخ: وقت:

Witness 2 گواہ

Signature دستخط:

Name نام:

Date and time تاریخ: وقت:

If an interpreter is used

Interpreter's Statement: I have accurately and completely read the foregoing document to the patient/patient's legal representative, in _____. They understood all the terms and conditions and acknowledged their agreement by signing the document in my presence.

Signature of interpreter ترجمان کے دستخط

Name of interpreter ترجمان کا نام

Date and time تاریخ: وقت: