GOVERNEMNT STANLEY MEDICAL COLLEGE

DEPARTMENT OF MEDICAL GASTROENTEROLOGY

PROFESSOR DR. M.S. REVATHY UNIT

CONSENT TO MEDICAL PROCEDURE

NAME	[redacted]
AGE/SEX	[redacted]
IP.NO	[redacted]

[redacted]

I, Dr Prof. M. S. Revathy .....have explained the nature, risks and possible consequences of the medical procedure to the undersigned patient or his/her legal guardian.

Signature..... Date 15/2/19

Procedure explained	Personally	Via interpreter

Nature of procedure ..... Endoscopic procedure (Endoscopic Ultrasound) .....

Where applicable indicate side of procedure: (right/left).....

Type of anaesthetic	Local	General ✓	Spinal	Procedural sedation

CONSENT TO USE OF BLOOD and/or blood products during the course of procedure

Consent granted by patient/guardian ✓

Consent withheld by patient/guardian.....

Signature [redacted]

Full name of the patient: [redacted]	I, the undersigned, hereby consent to the performance of, and understand the nature, risks and possible outcomes of the above procedure. the doctors who perform the above may carry out additional or alternative measures(including general anaesthesia) if considered necessary.
Signature/Thumbprint of the patient [redacted]	Date 15/2/19

COMPLETE THIS SECTION IF CONSENT IS GIVEN BY A PERSON ON BEHALF OF THE PATIENT

PATIENT NAME.....

SIGNATURE..... NAME.....

RELATIONSHIP TO THE PATIENT.....

MEANS BY WHICH CONSENT WAS GIVEN: ✓PERSONALLY TELEPHONICALLY

Names and signatures of witnesses to the patient's/guardian's signature on this document

Witness 1 [redacted]
Name
Signature.....

Witness [redacted]
Name
Signature.....