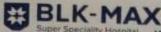
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I run a highe	r risk of co	mplications includ	ling risk to life and I give	consent fo	r the pr	ocodura
· III VIEW OI	me above:	Information I auth	miring D. C. V. Take			
			her to perform any par			
I also give	consent to	the services of an	other expert if there is a r	need during	or after	the pro
of the same	e has been	provided to me/my	y family by the bosoital I	ed Cost of	treatmen	nt and th
the estimat	e given to i	me is only an appr l condition.	oximation and final bill me	ay vary dep	ending (	pon the
. I have also	been expl	ained that during	the procedure some alte	ration in the	e manad	rement r
required in	the best inte	erest of the patient	. I give my consent for any	such chang	ge if dee	med nec
I certify that t I have under:	these have stood thes	e been explained se risks and willfu	to me in my own langu illy agree to undergo th	uage or the	rough a	n interp
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	The Country of the Co		Designation .		Date 12	1527
taken by	Cinnature		DLV Married		Thomas	100
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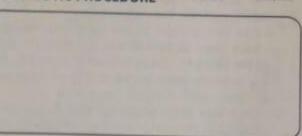
## INFORMED CONSENT FOR MEDICAL TREATMENT/ SURGERY/DIAGNOSTIC & THERAPEUTIC PROCEDURE





INSTRUCTIONS FOR USE:

The purpose of the informed consent is to educate the patient about his/her illness and to participate in decision making about his/her treatment. Therefore the consent is being taken in the language he/she understands. This consent formshould be signed by the patient if an adult (18 years or older).



Surrogate Decision Maker: If the patient is a minor or lacks the ability to make an informed decision the form should be signed by Surrogate decision maker, who can be spouse, adult children, parents, adult siblings or guardian (in order of priority)or a close friend may sign the consent form only in an emergency. The physician or his/her designee doctors are responsible for obtaining the informed consent. In case of life threatening/saving situations when next of kin are not available as detailed above, the treating physician is member of the management may sign as a witness.

The witness: The witness shall be spouse, adult children, parents, adult brothers or sisters, adult grandchildren, guardian/friend (in order of priority). The nurse or any other doctor(not from the treating team) or any member of the management may sign as a witness when none of above is available or in life threatening situation.

## DO NOT SIGN THIS FORM UNLESS YOU HAVE READ & UNDERSTOOD IT

	have been explained in a Language that I understand about my/my patient's clinical condition recovery, possible outcomes and alternatives(s)
)	I acknowledge that I was able to ask question and raise concerns with doctor about my patient's conditions, and the medical treatment/procedure/surgery. My questions and concerns have been discussed and answered to my satisfaction.  I hereby authorize the performance of the following surgery procedure (s) or treatment(s)  TORS ( Rt. Parapharyngcal Space Mare Excusor)
	upon my self/my patient Mr. /Mrs/Ms P·K· Thuseo ' (Name of Patient) The risks / benefits explained include but are not limited to the following:

The indications/aims of the procedure are as follows:

Cuartine

Re-extoration

## HIGH RISK CONSENT

I have been informed that due to the following reasons,