I run a higher risk of complications including risk to life and I give consent for the procedure.

- In view of the above information I authoirize Dr. S.K. Dabas and his/ her team as may be selected by him / her to perform any part of the above procedure/surgery upon myself/ the patient.
  I also give consent to the services of another expert if there is a need during or after the procedure I have been explained and counseled in detail about the Estimated Cost of treatment and the copy of the same has been provided to me/my family by the hospital. I have also have been informed that the estimate given to me is only an approximation and final bill may vary depending upon the length of stay and medical condition.
- I have also been explained that during the procedure some alteration in the management may be required in the best interest of the patient. I give my consent for any such change if deemed necessary.

I certify that these have been explained to me in my own language or through an interpreter; I have understood these risks and willfully agree to undergo the said procedure.

Consent taken by	Name [redacted]		Designation [redacted]	Date	13/10/22
	Signature [redacted]		BLK-Max Id [redacted]	Time	

AUTHORIZATION BY PATIENT

I have had the opportunity to ask questions about the procedure, the alternatives and the risks and benefits of not undrgoing the procedure, in the language and manner which I fully understand. I acknowledge that all my queries are answered to my full satisfaction.

Consent given by	Name	Address	Relationship with patient	Signature	Date
Patient	[redacted]				
Witness					

Witness can be either of one
Mother / Father/ Spouse/Son/Daughter/Grandson/Granddaughter/Close Friend*/ Guardian*/Nurse*/Doctor**
***only in case none of others are available**
****not from the treating team**

AUTHORIZATION BY SURROGATE DECISION MAKER OF THE PATIENT

The patient is unable to give consent because : _____
and I, _____(name / relationship to the patient) therefore, give consent of the patient. I acknowledge that I have had an opportunity to discuss my patient's management, with the physician/designee, and hereby consent for the same.

Consent given by	Name	Address	Relationship with patient	Signature	Date
Surrogate					
Witness					

Witness can be either of one
Mother / Father/ Spouse/Son/Daughter/Grandson/Granddaughter/Close Friend*/ Guardian*/Nurse*/Doctor**
***only in case none of others are available**
****not from the treating team**

BLK-MAX
Super Speciality Hospital

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 signing as the surrogate decision maker, the nurse or any other doctor (not from the treating team) or any 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
CONSENT

- I have been explained in a Language that I understand about my/my patient's clinical condition, have been explained about the potential benefits, risks associated, problems related with the recovery, possible outcomes and alternatives(s) available of the proposed medical treatment/procedure/surgery.
  I have also been explained about possible outcomes of non-treatment and also the likelihood of success of treatment.

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 t o my satisfaction.
I hereby authorize the performance of the following surgery procedure (s) or treatment(s)

TORS (Rt. Parapharyngeal Space Mass Excision)

upon my self/my patient Mr. /Mrs/Ms P.K. Thusoo

- (Name of Patient) The risks / benefits explained include but are not limited to the following:
  Bleeding, Infection, Major Vessel / Nerve Injury, Re-exploration
- The indications/aims of the procedure are as follows:
  Malaise

HIGH RISK CONSENT

- I have been informed that due to the following reasons,