Imprint Patient Hospital card:

CONSENT TO DIAGNOSTIC OR OPERATIVE PROCEDURES OR ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS(S)

Patient's Name ____________________________

I hereby authorize______________________________ of the Astra Minimally Invasive
Name of Health Practitioner
Surgery Unit, and whomsoever he/she may direct or delegate to assist him/her to perform the following:

Procedure____
Full Name of Operation(s), test(s) or treatments(s)

and such additional or alternative procedure(s) as are considered immediately necessary during the course of the said procedure(s). I understand that these additional procedures may be done in conjunction with Endoscopic Gynecological procedures in order to complete my investigations or to provide corrective treatment for unsuspected pelvic or uterine pathology. Those additional procedures include but are not limited to : ___ D&C / ____ Endometrial Sampling /___ Laparoscopic Lysis of Adhesions
___ Ablation of Pelvic Endometriosis / ___ Peritoneal Biopsy,Biopsy of Ovarian lesion
I further agree that in his/her discretion, the above-named practitioner may have the assistance of other physicians, surgeons, anaesthetists and health practitioners and may permit them to perform all or part of the procedure(s).

I acknowledge that the above named Health Practitioner has explained to me the nature of the procedure(s), the expected benefits, material risks and material side effects. He/she also explained to me the alternative courses of action and the likely consequences of not having the procedure(s). I fully understand all the information provided to me.

I certify that I have read this form and fully understand it.

______________________________ ______________________________
Signature of Patient/Substitute Decision-maker Date

____
Print Name of Substitute Decision Maker

☐ I have had a discussion about transfusion of blood and blood products with the above named health practitioner

BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS

☐ I consent to receive donor blood. I have received and had the opportunity to read the brochure *Transfusion of Blood and Blood Products.*

☐ I consent to receive blood products manufactured from donor blood.

I acknowledge that the nature of the treatment(s), the expected benefits, material risks, material side effects, alternative courses of action and the likely consequences of not having the treatment(s) have been discussed with me and all questions have been answered to my satisfaction

______________________________ ______________________________
Signature of Patient / Substitute Decision Maker Date

Statement of Health Practitioner

I confirm that I have explained the nature of the treatments(s), the expected benefits, material risks, material side effects, alternative course of action and the likely consequences of not having the treatments(s) to the above patient/substitute decision maker and answered all questions.

______________________________ ______________________________
Signature of Health Practitioner Date

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