ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM

AH 01AE19050
M155 N
FERGUSON
DOB 04/02/93

MEDICAL OR DENTAL INVESTIGATION TREA

Patient's Surname ..... Ferguson ..... AUG/SM DEPT .....

Other Names ..... Rachel ..... AH 313554 .....

Date of Birth ..... Hospital Number ..... Sex : *(please tick)* Male ☐ Female ☐

DOCTORS OR DENTISTS *(This part to be completed by doctor or dentist. See notes on the reverse).*

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate.

..... Appendectomy .....

.....

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ..... R Makan ..... Date : ..... 7/6/01 .....

Name of doctor or dentist ..... R Makan .....

PATIENT/PARENT/GUARDIAN

1. **PLEASE READ THIS FORM AND THE NOTES OVERLEAF VERY CAREFULLY**

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the	patient / parent / guardian	*(delete as necessary)*
I agree	•	to what is proposed which has been explained to me by the doctor/dentist named on this form.
	•	to the use of the type of anaesthetic that I have been told about.
I understand	•	that the procedure may not be done by the doctor/dentist who has been treating me so far.
	•	that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
I have told	•	the doctor or dentist about the procedures listed below I would **not** wish to be carried out without my having the opportunity to consider them first.

.....

.....

Signature ..... M FERGUSON .....

Name .....

Address .....
(if not the patient)

Date .....

LPC 04/98/008

020-008-015

RF – ALTNAGELVIN