General Consent for Examination and Treatment

Clinic: _____ Date: _____ Time: _____

Patient name: _____ Age / Sex: _____ OPD / Reg. no.: _____

1. I have come to this clinic for consultation, examination and treatment, and I agree to be examined and treated by the clinic's doctors and trained staff.

2. The doctor has explained my condition, the care planned, and the main choices in a language I understand. I have had the chance to ask questions.

3. I have told the doctor about my medical history, allergies, medicines I take, and any pregnancy as far as I know. I understand that incomplete information can affect my care.

4. I understand that no treatment gives a guaranteed result, and that I may need further tests, visits or treatment.

5. I agree that my records may be used for my care and shared with other doctors or labs involved in it. They will not be shared with anyone else except as the law requires or with my written permission.

6. I can ask questions or withdraw this consent for future treatment at any time.

Patient or guardian name and signature or thumb impression: _____

Relationship (if signing for the patient): _____

Witness name and signature: _____

Doctor name, registration no. and signature: _____

Language in which this was explained: _____

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Consent for a Procedure or High-Risk Treatment

Clinic: _____ Date: _____ Time: _____

Patient name: _____ Age / Sex: _____ OPD / Reg. no.: _____

Procedure planned: _____

Reason for the procedure: _____

1. The doctor has explained the procedure, why it is advised, how it is done, and what recovery involves.

2. I have been told the common risks and possible complications, including: _____ (doctor to fill in).

3. I have been told about other options, including not having the procedure, and what may happen in each case.

4. I understand that during the procedure the doctor may need to change the plan if something unexpected is found, in the interest of my safety, and I agree to this.

5. I have had enough time to think, my questions were answered, and I agree to the procedure of my own free will.

Patient or guardian name and signature or thumb impression: _____

Relationship (if signing for the patient): _____

Witness name and signature: _____

Doctor name, registration no. and signature: _____

Language in which this was explained: _____

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Consent for Anaesthesia or Sedation

Clinic: _____ Date: _____ Time: _____

Patient name: _____ Age / Sex: _____ OPD / Reg. no.: _____

Type planned (local / sedation / regional / general): _____

1. The anaesthesia or sedation, how it is given, and why it is advised have been explained to me.

2. I have told the team about my health, allergies, past reactions to anaesthesia, regular medicines, smoking, alcohol, and when I last ate or drank.

3. I have been told that anaesthesia carries risks, which can be higher with some medical conditions. The doctor has explained the main ones: _____ (doctor to fill in).

4. I have been given fasting and after-care instructions and I will follow them. I will arrange an adult to accompany me home if advised.

5. I agree to the anaesthesia or sedation, and to any change in type that is needed for my safety.

Patient or guardian name and signature or thumb impression: _____

Relationship (if signing for the patient): _____

Witness name and signature: _____

Doctor name, registration no. and signature: _____

Language in which this was explained: _____

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Leaving Against Medical Advice (LAMA)

Clinic: _____ Date: _____ Time: _____

Patient name: _____ Age / Sex: _____ OPD / Reg. no.: _____

1. My doctor has advised that I should continue treatment / stay under observation at this clinic for: _____.

2. I have been told the possible risks of leaving now, which may include worsening of my condition, complications, or serious harm, as explained to me: _____ (doctor to fill in).

3. I have decided to leave, or to take the patient home, against this advice, of my own free will. I understand I can return for care at any time.

4. I release the clinic and its doctors from responsibility for the outcome of this decision. This does not limit my right to receive proper care in future.

5. I have been given advice on warning signs and what to do, and the name of a doctor or facility to contact in an emergency.

Patient or guardian name and signature or thumb impression: _____

Relationship (if signing for the patient): _____

Witness name and signature: _____

Doctor name, registration no. and signature: _____

Language in which this was explained: _____

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