Dr. PJ (Pieta) Geyser

MB ChB (Stell) MMed (OetG) (Pret) FCOG (SA)

Ginekoloog & Verloskundige • Gynaecologist & Obstetrician

Kerkstraat 148
Rustenburg, 0299
Postnet Suite 83
Privaatsak X82329
RUSTENBURG, 0300

Pr. 1609815

Tel. (014) 594 0340
(014) 594 0341
Faks (014) 594 0342
Tel. (014) 592 7059 (H)
Sel. 083 457 4980

CONSENT FORM

Patient:_____ Date of Birth:_____

DOCTOR

(To be completed by Doctor Geyser)

I confirm that I have explained the following to the patient in terms which, in my judgment, are suited to the understanding of the patient and / or one of the parents or guardians of the patient (Please tick):

- The patients health status and condition;
- The range of diagnostic procedures and treatment options generally available to the patient;
- The benefits, risks, costs and consequences generally associated with each option;
- The patients right to refuse health services and the implications, risks, obligations of such refusal;
- The nature and purpose of the proposed operation, investigation or treatment, namely:_____
  _____
  _____
- The type of anaesthetic, If any (general / local / sedation) _____
- The possible need for blood or blood products during and after the procedure and the risks associated with receiving blood or blood products.

Signature: _____ Date: _____

Name of Doctor: Dr PJ Geyser

PATIENT / PARENT / GUARDIAN / MANDATED PERSON

(To be completed by Patient / Parent or Guardian)

I, the undersigned state as follows:

- I am the patient / parent / guardian (Indicate please)
- The doctor named on this form has explained fully to me the issues listed and ticked above;
- I confirm that I understand everything that has been explained to me. I have also received answers to all my questions and been informed that, If I want more information, I should ask the doctor;
- I understand that problem(s) and complications may occur even when the best care, judgment and skill are used. No guarantees have been promised to me by Dr PJ Geyser.;
- I agree to the operation, investigation or treatment as explained to me, and to the use of the type of anaesthetic that I have been told about, as well as the possibility of transfusion of blood and / or blood products as may be considered necessary or desirable by the doctor;
- I have been told 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 that I **do not** want the procedures listed below to be carried out without my having the opportunity to consider them first:_____
- I consent to the retention and / or disposal by the health facility and / or doctor of any tissue or parts which may require removal;
- I understand that I may withdraw consent to, or refuse treatment at any time.

Signature:_____ Name of Patient / Parent / Guardian:_____

Date:_____ Witness 1: _____ Witness 2: _____