



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive  
South

**DOCTOR to complete**

## CORK UNIVERSITY HOSPITALS GROUP

### CONSENT TO SURGERY OR A DIAGNOSTIC OR THERAPEUTIC PROCEDURE

Statement of doctor (to be filled in by the doctor who has appropriate knowledge of the proposed procedure to discuss the procedure fully with the patient)

I have explained the procedure to the patient. In particular, I have explained the following.

These are the intended benefits:

These are the serious or frequently occurring risks:

These are any other procedures that may become necessary during the procedure, including blood transfusion and tissue removal and examination, including the following (please specify):

I have also explained to the patient what the procedure is likely to involve, alternative treatments (including no treatment) and the benefits and risks of the alternative treatments, and I have discussed the patient's concerns and answered the patient's questions if any. I have explained the purpose for which any tissue is taken and that the tissue may be retained as part of the patient record.

Special requirements (interpreter used to explain consent, sign language used, etc)

Doctor name (block capitals)

Date

—	—	—
day	month	year

Doctor signature

Job title

I have explained the risks and benefits of the type of anaesthetic to be used as follows:

general and/or regional anaesthesia     local anaesthesia     sedation

Anaesthetist name (block capitals)

Date

—	—	—
day	month	year

Anaesthetist signature

Job title

## CONSENT TO SURGERY OR A DIAGNOSTIC OR THERAPEUTIC PROCEDURE

I understand the information on the other side of this page and I consent to the procedure as it was explained to me. In addition, I understand the following points.

1. Dr \_\_\_\_\_ will perform or supervise the performance of this procedure. I authorize the doctor performing this procedure to have the assistance of other doctors (including registrars and senior house officers) as s/he considers advisable.
2. I consent to receive blood or blood components I may need. The risks of receiving blood, the risks of not receiving blood or blood components and any alternatives have been explained to me.
3. I understand that any tissue sample removed from my body during this procedure may be used for diagnostic and therapeutic purposes as part of my care, that the specimen taken will be stored as part of the record of my treatment and that the record and specimen may be of benefit to my subsequent treatment.
4. Cork University Hospital is a teaching hospital and teaching and research is part of the Hospital's role. For the purpose of training doctors and nurses, I consent to observation of this procedure by qualified observers including medical and nursing students.

Patient signature

Date

  
day month year

Parent or guardian signature (if relevant)

Date

  
day month year

Witness name (block capitals)

Witness to signature

Date

  
day month year

I have read the information on the front side of this page and this page and I **do not consent** to this point:

Patient signature

Date

  
day month year

Parent or guardian signature (if relevant)

Date

  
day month year

Witness name (block capitals)

Witness to signature

  
day month year