Informed Consent – Dr ALJ du Toit

I, …….. the undersigned,
Name of patient/parent/guardian

Hereby consent to the performance of

……..……...

……..……...

……..……...
Nature of procedure(s)

On……, under anesthesia
Name of patient

I acknowledge that the surgeon has explained to me:

- The nature and purpose of the procedure, the risks involved, alternatives to above proposed treatment and the possibilities of complications to my satisfaction and all my questions were answered.
- That a satisfactory result is expected but that the following are some of the complications or side effects that could or may occur, including but not limited to: Bleeding, infection, damage to adjacent tissues, nerves, blood vessels or organs, swelling, pain, blood clots and emboli, suture reaction, recurrence, hardware failure, additional operations, and in rare cases, paralysis, loss of a limb or part thereof or death.
- That no guarantee is given to me by anyone as to the results that may be obtained.
- That any additional procedures may be performed by the doctor which he deems necessary or advisable and in my best interest during the course of the procedure.
- That photographs/x-rays/videos may be taken during the procedure for medical purposes and kept in my file and that all identifying characteristics will be removed.
- That my doctor may be assisted by others in the operating room and that a representative may be present during the procedure.
- That if the surgeon or other member injures him/herself during the procedure that I give consent that blood may be taken for HIV, Hepatitis studies or any other tests which may be clinically relevant.
- The possible type of anesthetic to me. A more detailed description of the anesthetic may be requested by me from the anesthetist.
- That I give consent that Dr ALJ du Toit may discuss my case with all participating specialists at the appropriate multi-disciplinary meetings as well as any other specialists that Dr du Toit may feel will be relevant regarding my diagnosis, previous and forthcoming treatment. All imaging and pathology results or any findings concerning my diagnoses may be disclosed and discussed.
- I also give consent that any clinical data and results may be anonymized and used for research purposes. I may withdraw my consent at any time by submitting it in writing to the practice.
- I do not suspect that I am pregnant at this time and understand that if I am there is a possible risk to my unborn child.
- I am not known to be allergic, and do not have intolerance to anything except:
  ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Latex ☐ Contrast Dyes
  ☐ Adhesive tape / Dressings / Plasters Other: .....
- I consent to the use of blood/blood products during/after the procedure if indicated: ☐ Yes ☐ No
- I have been informed of the practice billing policy and rates applicable to me:
  ☐ Medical Aid Rates ☐ Non-Contracted Rates with quote accepted and signed by myself
- That I am encouraged and invited to ask any further questions I may have.
- That I may inform him and withdraw my consent any time prior to the proposed procedure named above.

……
Signature of patient/father/mother/guardian/next of kin

…….. ……/……/…….. ……..
Signature of Dr ALJ du Toit *Date* *Time*

……..
Signature of Witness