No.

Individual Patient Consent Form

*To the patient: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether* to *undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been* recommended. *This consent form is simply an* effort *to obtain your permission to perform the evaluation necessary* to *identify the appropriate treatment for any identified condition(s).*

This consent provides \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and other health care providers to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care. I understand that if additional testing, invasive or interventional procedures are recommended I will be given a referral to a higher level patient facility.

I certify that I have read and fully understand the above statements and consent fully and voluntarily.





\*If translated: I have accurately read the information sheet to the patient and have to the best of my ability made sure that the patient understands what they are consenting to and has had the opportunity to ask questions

\*If for some reason the patient cannot read the Information sheet and consent for themselves. I confirm and witness that I have accurately read to the patient and have to the best of my ability made sure that the patient understands what they are consenting to and has had the opportunity to ask questions.

Thumb Print of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness

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**Printed: Name of Witness**

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**Date**