CONSENT TO OPERATION/S WITH DR MICHELE LONG

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF OPERATION:

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In signing this consent form, I agree that:

* The doctor has described the operation well enough for me to understand it.
* The doctor has explained why the operation is advised and what the alternatives are to the operation.
* The doctor has explained what benefits can realistically be expected from the operation.
* The doctor has explained the risks, complications and possible side effects of the operation.
* The doctor has answered the questions I wanted to ask about the operation.
* I do wish the doctor to proceed with the operation.
* If the doctor finds in the operation that additional procedures not list above are necessary, she may do them, as long as they are in my best interests.
* If any authorized staff including nursing staff or the doctors are accidentally exposed to my blood/bodily fluids during the procedure/s; I consent to a blood sample being tested for the Human Immunodeficiency Virus (HIV) and/or Hepatitis screen so as to facilitate post-exposure prophylaxis to the injured staff member.
* Additional charges will be billed for BMI.
* Dr Long charges 217% above medical aid rates for surgical procedures. The member is liable for this account if not covered by the medical aid plan.

PATIENTS NAME: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE:­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Adult or child over 12 years)

PARENT/GUARDIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_