

# GENERAL INFORMED CONSENT



**DOCTOR:**  
**A JACOBSZ**

**PRACTICE NUMBER:**  
**0488682**

Surgery to be performed in:  Arcadia  Faerie Glen  Benoni

### SURGEON STATEMENT

The patient has been informed as to the **Diagnosis, Treatment, Risks, Complications, Alternatives and Benefits** of the condition and treatment.  
 I am of the opinion that the Patient/Parent/Guardian/Legal Representative, as decision-maker, has understood the content of the **Informed Consent**.

Patient  Parent  Guardian  Legal Representative

OPHTHALMOLOGIST SIGNATURE

DATE

### PROCEDURE DETAIL

**Patient Diagnosis:**

**Procedure to be Performed**  
(with laterality, no abbreviations):

**LEFT**

**RIGHT**

### PATIENT CONSENT

PATIENT

PARENT (Children 18 years and younger)

GUARDIAN

Court Documentation Cleared (copy attached)  yes  no

LEGAL REPRESENTATIVE

Court Documentation Cleared (copy attached)  yes  no

INTERPRETER

Interpreter Name:

I, Prof / Dr / Mr / Mrs / Ms / Rev :

have read, understood and agree to

the Informed Consent, I understand that I can change my mind at any time and that I have the right to seek a second opinion.

I freely and voluntarily sign the following for Myself  / or Patient's Name: \_\_\_\_\_

- I have been informed and understand what the procedure entails, my medical condition, diagnosis, and the proposed procedure, including additional treatment if the doctor finds something unexpected and the risks associated with, or of not having the procedure.
- I appreciate, understand and consent to the nature of the harm or risks/complications/benefits and alternatives including the risks that are specific to me and I have informed the doctor and personnel of all allergies and medications currently being taken.
- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand my responsibility to follow instructions for my eye care, before and after the surgery.
- The Pretoria Eye Institute will provide the theatre, facilities, trained staff, consumables and equipment as needed.
- If at any stage during the procedure, if I cannot consent to further interventions and if it is needed and possible to contact such a person, I hereby nominate \_\_\_\_\_ (name and surname), who is \_\_\_\_\_ (describe relation), with contact number : \_\_\_\_\_ to provide such consent on my behalf.
- I further agree that image/s or video footage may be recorded as part of and during my procedure if, in the Doctor's opinion these images/s or video/s will assist in providing appropriate treatment.

### NAME & SIGNATURE

PATIENT / PARENT / GUARDIAN / LEGAL REPRESENTATIVE

DATE

WITNESS

DATE