	SRINAGARIND HOSPITAL FACULTY OF MEDICINE KHON KAEN UNIVERSITY	HN _____ AN _____ NAME _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F AGE IN YEARS _____ DEPARTMENT _____	Ward _____ Attending Staff _____ Resident _____ Diagnosis 1 _____ 2 _____ 3 _____
	CONSENT FORM 2		

Consent Form to Allow the Doctor or Hospital Staff to do a procedure or investigation/special treatment

Done at _____

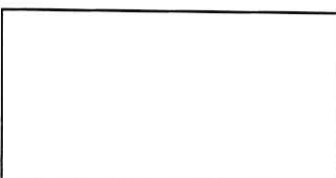
Date _____ Time _____

I, Mr/Mrs/Miss _____ age _____ house number _____ Street _____

Tambol _____ Ampur _____ Province _____ for myself relative with the right to make decisions for the patient do consent voluntarily for the doctor or the Faculty of Medicine and the employees of Srinagarind Hospital whose duties require them to participate in the treatment of myself Mr/Mrs/ Miss/Master/Mistress _____ to continue treatment by _____ I understand the details with the plan of treatment set for me as well as the benefits, possible effects, and the risks which might happen during or after treatment such as _____

and alternative methods of investigation/treatment such as _____ which were clearly explained to me by _____

I am fully conscious and aware that the Faculty of Medicine and the hospital team caring for me cannot completely guarantee the results of the investigation/treatment I consent do not consent _____ (in the event you do not consent make an **X** in the consent box and put a check mark in the do not consent box and sign your name and put your authority under the line also) to receive the investigation/special treatment as explained which may include sedation, anesthesia, administration of blood and/or blood products, research investigation or radiation, take a biopsy or remove a portion of a body part. While investigating or treating as mentioned above, if the treating doctor finds it necessary to do further investigation or treatment or suddenly do more extensive surgery, I give my permission for the doctor to proceed considering the health benefits to the patient as necessary and appropriate and/or the importance of saving the life of the patient.


Thumbprint of Patient** <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Other _____ Identification _____

signed _____ Patient Family* who makes decision

print name _____

*relationship to the patient _____ date _____

signed _____ Person giving information about procedure/
investigation/special treatment

print name _____ date _____

Witnesses that patient/family who makes decision did consent or sign or give thumbprint

signed _____ Witness

print name _____ date _____

signed _____ Witness

print name _____ date _____

**If unable to write name

State reason that patient is unable to consent
 () of minority age
 () guardian for body/mind Explain _____
 () other Explain _____

Passport/Identity Card Number of Person Consenting
 Type _____
 Citizenship _____ Number _____
 Date of Issue _____ Expiry date _____
 Place of Issue _____