	SRINAGARIND HOSPITAL FACULTY OF MEDICINE KHON KAEN UNIVERSITY	HN AN NAME SEX ☐ M ☐ 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**

○ Left ○ Right
○ Other _____

Identification_____

**If unable to write name

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_____

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_____