Consent for In Patient Hospital Treatment

Part 1 Consent for Treatment Date Time

I, ○ Mr ○ Mrs ○ Miss _____ consent to be admitted to Srinagrind Hospital for treatment and agree to answer questions about the history and to receive treatment and blood transfusions for ○ myself ○ patient _____.

Thumb Print of Consenter ○ Left ○ Right ○ Other _____	Signature _____ Print name _____ ○ Self ○ Father/Mother ○ Spouse ○ Child
Identification of Consenter Type _____ Number _____ Issued by _____ Date issued _____ Expiration date _____	Witness _____ Print Name _____ Witness _____ Print Name _____

The patient must sign for himself unless the patient is a minor or unable to due to physical or mental incapacity. In that case, an heir or a close relative can sign. The signatory must clearly understand the treatment to be given.

Part 2 Request for patient discharge against medical advice

Date _____

I am taking _____

who has been being treated at the hospital on ward _____ because the patient wants to leave and understand the patient's condition at this time. I will be responsible for all consequences which may happen if the patient leaves the hospital now.

Signature _____

Print Name _____

Witness _____

Print Name _____

Part 3 Refusal of hospital admission

Date _____

I do not consent for the patient _____ who is my _____ to be admitted to this hospital. Hospital officials have explained very clearly to me why they suggest hospitalization. I will be responsible for all consequences of refusing admission and will not hold the hospital responsible should some untoward even occur in the future as a result of my decision.

Signature _____

Print Name _____

Witness _____

Print Name_____

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Witness_____

Print Name_____

Witness_____

Print Name_____

Thumb print of consenter*

○ Right ○Left
○ Other_____

Thumb print of consenter*

○ Right ○Left
○ Other_____

National Identity Card of Person Taking Patient

Type _____ Number_____

Issued by_____

Date Issued_____Expiration date_____

National Identity Card of Person Taking Patient

Type _____ Number_____

Issued by_____

Date Issued_____Expiration date_____

*If unable to write their name