

**CONSENT FOR SURGERY**

I.....ID.....

hereby give my consent for the performance of.....

..... on Me/Patient

Dr ..... Has provided me with the general explanation of the nature of this operation and the reasons why it is indicated for my/the patient’s medical condition. Dr ..... has discussed the **risks and benefits of the operation** including alternatives. Serious and common risks related to the proposed surgery include:

I/We acknowledge that some of the **serious and common complications** listed above were discussed and are aware that this is not a full list and other unforeseen adverse events could occur.

I hereby grant consent to any **hospital and other health care services** that are medically indicated or that the doctor may prescribe or require including any surgery, radiology, diagnostic examination, anesthetic, blood or blood product infusion, or laboratory tests (**including an HIV test in the event of a needle-stick injury to one of the healthcare team**) for me/the patient. The doctor explained to me that other physicians and health care providers will participate in my/the patient’s care. I therefore extend this authorization to these physicians and health care providers. I understand that I am/the patient is **responsible for the fees** as explained to me by the doctor. or, if not specifically explained, for the **customary fees for any services**. I understand that I/the patient may be responsible for **co-payments** for any orthopaedic prosthesis/implants, bone graft/substitutes required, hospital co-payments or any other expenses that are not covered by my Medical Aid.

I consent to the presence of a **company representative** should the doctor elect that he/she be present in theatre. It is understood that the company representative advises the theatre staff on his/her company’s medical devices to be used. I consent / do not consent to the taking of **photographs and collecting or using clinical information** for clinical/research/registry purposes only. I understand that the doctor will not use these photographs or information in any manner that will identify me.

I acknowledge that the following conditions specific to the **COVID-19** pandemic have been explained to me and I understand that:

1. There are general risks attached to COVID-19 infection and that viral shedding during the prodrome period and that a significant proportion of patients in SA appear to be COVID-19 positive with no symptoms at all.
2. There is no current treatment for COVID-19 and that vaccines are unlikely to be available for at least 6-12 months.
3. COVID-19 infection carries a risk of death and this is increased with age, the presence of comorbidities and the duration of the surgical procedure.
4. Despite feeling completely well I/we may still be or become infected with the COVID-19 virus and there is a significant risk of serious illness or dying after any surgical procedure as a result of this infection.

After discussing the above, the Dr ..... gave me an opportunity to ask questions and seek further information. I do not require further information and I am prepared to consent to him/her proceeding with the recommended operation. I believe that the doctor has honoured my right to **make my own informed health care decision**. I give my consent voluntarily and freely and certify that I can give valid consent. I understand that I can revoke my consent to the operation at any time up until the time the operation process has started. I also consent to my/the patient’s personal information including information relating to my/the patient’s health and treatment being processed or given to any person necessary in relation to the operation and related treatment and payments due.

In the event of allegations of negligence, I agree to **embark on mediation** prior to embarking on litigation.

.....  
PATIENT / GUARDIAN/  
AUTHORISED HERETO BY LAW

.....  
DATE

.....  
WITNESS