DR FRANCOIS SWART
NEUROSURGEON

MB ChB DA DipPEC M Med
PR no: 0240000451118
MP no: 0450014

INFORMED CONSENT TRIAL OF INTRATHECAL DRUG THERAPY

I (Full name), _____

ID:_____

ACKNOWLEDGE THAT:

The doctor has explained my medical condition and the proposed surgical procedure. I understand the risks of the procedure, including the risks that are specific to me, and the likely outcomes.

I was able to ask questions and raise concerns with the doctor about my condition, the procedure and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.

I understand that the procedure may include a blood transfusion.

Should any unexpected pathology be found during my operation, I agree that the doctor may modify the surgical plan appropriately.

The doctor has explained to me that if immediate life-threatening events happen during the procedure, they will be treated appropriately.

I understand that photographs may be taken during my operation.

I understand that no guarantee has been made that the procedure will improve the condition, and that the procedure may make the condition worse.

I understand that it is common practice to have a representative from the medical devices/ pharmaceutical industry present during the operation, if deemed appropriate by Dr Swart.

I understand that my medical insurance/funder may not cover the complete cost of the procedure, that I am responsible for payment of the account and I am aware that a quote for the procedure is available on request.

Based on the above statements, I request to have the procedure.

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Cnr Garsfontein Road & Netcare Street,
Moreletapark, 0044

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DOCTORS STATEMENT:

I have explained:

- the patient's condition
- need for treatment
- the procedure and the risks
- relevant treatment options and their risks
- likely consequences if those risks occur
- the significant risks and problems specific to this patient

I have given the patient an opportunity to:

- ask questions about any of the above matters
- raise any concerns

which I have answered as fully as possible.

_____

Name of patient or parent / guardian if minor

_____

Signature:

_____

Date:

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