

Personal Information, Medical Services and/or Surgery Consent Form
Written at Sunpasitthiprasong Hospital
Date _____ Month _____ Year _____
“I” ☐ (Patient Name) _____
☐ (Patient Representative Name) _____ Relationship to the Patient _____

 Patient Name: _____ understands all information and **CONSENT** for Sunpasitthiprasong

Hospital personnel to perform all needed medical services and/or any surgical procedures. (Specifically): _____

in order to discover, care for, promote, prevent and all needed procedures to facilitate patient recovery including mental health, all reasonable treatments, surgical procedures, and all nursing care plans in order to choose the best procedures for the administration of anesthesia. This includes all medicinal injections while being cared for regardless of outcome, risks or complications that may arise.

Sunpasitthiprasong Hospital personnel have explained and I have read all this information and understand it in full leading to my signing or rendering my fingerprint on this form as proof thereof.

Signed: _____ (Consenting Party)

Signed: _____ (Patient Witness) Relationship: _____

Signed: _____ (Title of Informing Official) _____

Signed: _____ (Title of Witness for Informing Official) _____

Note: ☐ Patient came into hospital alone. ☐ Patient was unconscious or not lucid upon arrival.

Personal Information, Medical Services and/or Surgery Non-Consent Form
Written at Sunpasitthiprasong Hospital
Date _____ Month _____ Year _____
“I” ☐ (Patient Name) _____
☐ (Patient Representative Name) _____ Relationship to the Patient _____

 Patient Name: _____ understands all information, reasons and needs concerning treatments, surgical procedures, nursing care plans in order to discover the best care for and in order to choose the best procedures for the administration of anesthesia. This includes all medicinal injections while being cared for regardless of outcome, risks or complications that may arise. But, **I DO NOT CONSENT** to allowing Sunpasitthiprasong Hospital personnel to perform any care, surgical procedures.

(Specifically): _____.

And if any adverse or dangerous consequences arise regardless of type in my life, I accept those circumstances and understand that there is no liability or responsibility on the behalf of personnel or any other government officials of Sunpasitthiprasong Hospital.

Signing my name or rendering my fingerprint on this form as proof thereof.

Signed: _____ (Non-Consenting Party)

Signed: _____ (Patient Witness) Relationship: _____

Signed: _____ (Title of Informing Official) _____

Signed: _____ (Title of Witness for Informing Official) _____

Note: ☐ Patient came into hospital alone. ☐ Patient was unconscious or not lucid upon arrival.

NAME OF PATIENT: _____ AGE: _____ HN: _____

DEPARTMENT OF SERVICE: _____ WARD: _____ ATTENDING PHYSICIAN: _____

CONSENT OR I DO NOT CONSENT NOTE