Ministry of Health and Quality of Life

CONSENT FORM FOR ADMISSION

Hospital ....Unit Number ....

Name of Patient .... N.I.C No ....

Name of Responsible Party/Legal Guardian

.... N.I.C No ....

Relationship to Patient .... Date of Admission.....................

I, (a) the above-named patient (b) Responsible Party of the above-named patient (c) Legal Guardian of the above-named patient*, have taken cognizance and **give my consent/do not give my consent*** to the following.

a. Procedures undertaken during this hospitalisation may include but are not limited to laboratory procedures, x-ray examinations, diagnostic procedures, medical, nursing or surgical treatment or procedures, tele-health services or hospital services rendered to me as ordered by my treating doctor/s or other health care professionals on the Hospital's medical staff.

b. I agree to the use of anaesthesia and/or sedation/analgesia/contrast medium as required, and if applicable, the disposal of any removed tissue from my body.

c. I authorise the Hospital and the treating doctor/s to photograph, video and/or use any other media which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorisation, which are not required by law to be retained, may be disposed by the hospital so long as the manner of disposal shall be permanent destruction.

d. Medical and Health Officers (MHO), medical students under the supervision of a specialist and/or MHO, physician assistants or registered nurses may be in attendance and/or assist in the performance, and/or perform significant medical/surgical tasks and/or special procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing special procedures/treatments which may require the assistance of other qualified medical personnel who have not been identified above.

e. That as part of their training, students in health care may participate in the delivery of my medical care and treatment or as observers while I receive medical care and treatment at the hospital under a fully qualified and registered medical officer.

f. The hospital may conduct testing for infectious diseases including but not limited to testing for Hepatitis, Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV), if a physician orders such tests.

g. The hospital may disclose my health-related information for purposes of treatment or operations.

** delete as appropriate*

Please turn over

h. My healthcare information may also be disclosed for the purposes of communicating results, findings, and care decisions to my family members and others responsible for my care; and

i. My health care information may be used for the purposes of planning of health services and conducting medical research, provided my identity is not revealed.

Obstetrics patients
If I deliver an infant(s) as an inpatient of this hospital, I agree that these same Conditions of Admission will apply to the infant(s).

Risks
I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment.

Blood tests
I understand that the potential side effects and complications of blood testing are generally minor which include discomfort from the needle and/or slight burning, bleeding or soreness at the puncture site.

Safekeeping of personal belongings
As a patient, I should leave personal items at home.

I understand that the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, garments, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or any other personal property unless deposited with the hospital for safekeeping.

Payment of fees
I understand that I **am/am not*** a citizen of the Republic of Mauritius and as such I **do not have to incur/have to incur*** costs arising from my hospital stay.

For guardians of minors and incapacitated patients
I, the undersigned, acknowledge and verify that I am the legal guardian/responsible party* of the minor/incapacitated patient.

I have been given the opportunity to read and ask questions about the information contained in this form and I acknowledge that I have no questions/that my questions* have been answered to my satisfaction.

Name of witness ....

N.I.C Number ....

Signature ....

Date ....

....

Signature of Patient

or Responsible Party

or Legal Guardian*

Date ....

Thumbprint

** delete as appropriate*

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