PATIENT CONSENT FOR MEDICAL CONSULTATION AND EXAMINATION

Clinic: [Insert clinic name]
Doctor: Dr. Shagun Rao
Medical Registration Number: [Insert registration number]

Patient Details

- Full Name: _____
- Age / Date of Birth: _____
- Patient ID (if applicable): _____
- Contact Number: _____
- Date and Time: _____

1. Consent for Consultation

I understand that the purpose of the consultation is to discuss my symptoms, medical history, concerns, and available healthcare options.

I have been given an opportunity to explain my symptoms and ask questions. I understand that I should provide accurate and relevant medical information, including current medicines, allergies, previous procedures, and relevant medical conditions.

2. Consent for Examination

I understand that the doctor may recommend a physical examination relevant to my symptoms and clinical condition.

Before any intimate examination or examination involving sensitive body areas, the doctor should explain its purpose and obtain my appropriate consent. I may ask questions, request an explanation, or ask for the examination to stop.

A chaperone may be offered or arranged in accordance with clinical circumstances and applicable professional guidance. Any refusal or request regarding a chaperone should be documented as appropriate.

3. Diagnosis and Treatment Discussion

I understand that a diagnosis may require further investigations or review of medical records. The doctor may explain suitable treatment options, expected benefits, material risks, alternatives, and the consequences of delaying or declining treatment.

I understand that no particular outcome can be guaranteed.

4. Consent and Voluntary Participation

I have had an opportunity to ask questions and receive explanations in a language I understand.

I understand that I may decline a proposed examination or treatment, subject to discussion of the possible consequences and any urgent clinical considerations.

This form does not replace a separate written informed-consent form required for surgery, an invasive procedure, anesthesia, or another intervention where specific consent is appropriate or required.

5. Patient Declaration

I confirm that the information provided by me is accurate to the best of my knowledge and that I have understood the information above.

Patient/Authorized Representative Name: _____

Signature / Thumb Impression: _____

Relationship to Patient, if applicable: _____

Doctor / Healthcare Professional: _____

Signature: _____

Date and Time: _____