Patient Informed Consent Documentation

Patient Information

Full Name

Date of Birth

Patient ID / Number

Treatment/Procedure Information

Name of the Treatment/Procedure

Description

Potential Risks and Benefits

Risks

Benefits

Alternative Options

Patient Acknowledgement

☐ I confirm that I have read and understood the information provided above.

- [ ] I have had the opportunity to ask questions and they have been answered.
- [ ] I understand that my participation is voluntary and I can withdraw at any time.

Patient Signature: Date:

Physician/Clinician Signature: Date: