Labaid Cardiac Hospital
CARE FIRST...

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AUTHORIZATION FORM

HN:H..... AN:LCH :..... Date :.....

Patient's Name :..... Age :..... Gen :.....

Consent is hereby given to the staff of the Labaid Cardiac Hospital (LCH) for the performance of diagnostic examination, diagnostic or therapeutic procedure, transfusion, operation under any anaesthetic agent (local or general) that may be necessary for my proper care during the course of my stay at LCH.

During my evaluation and treatment at LCH, need may arise for transfusion of blood/blood products as life saving measure. I have been explained that despite taking all precautions and conducting all mandatory tests conforming to international standards for screening of blood to ensure safe transfusion, it is not possible to completely exclude occasional case of Transfusion Associated Disease. I accept the risk of blood transfusion. Consent is also given for the performance of HIV(AIDS related) test. I fully understand that a positive test does not indicate disease. It only means further investigation is required.

I am aware that during the Surgical operation/procedures and administration of anaesthesia a mishap/accident/organ failure/organ dysfunction/even death may happen; for which the treating team/surgical team/anaesthesia team/attending doctors will not be held responsible; and I/my relatives will not unnecessarily harass them by putting into troubles/involving them into lawful actions/complaining to the courts or administration or any where else.

I hereby certify that I fully understood the nature of the above consents that have been fully explained to me.

Signature of Patient/Relative..... Relationship.....

Signature of Witness..... Name of Witness.....

RELEASE FROM RESPONSIBILITY FOR DISCHARGE

I am leaving/taking away my patient from the Hospital against the advice of the attending physician. I acknowledge that I have been informed to the risks involved and hereby release the attending physician and the Hospital from all responsibility for any effects that may result from such discharge.

Signature of Patient/Relative.....Relationship.....

Signature of Witness..... Name of Witness.....

● **Relative to sign only if the patient is minor or not in a physical condition to do so.**

For Medical Records Department Only

☐ Laboratory Report	☐ Echo Reports	☐ X-Ray Report	☐ Nuclear Reports
☐ Nurse's Record	☐ Cath Reports	☐ ECG Report	☐ Discharge Summary
☐ Doctor's Record	☐ Operation Notes	☐ Holter Report	☐ Death Certificate

Cause of Death.....