

|                                    |     |                 |                        |                                    |     |                 |                        |
|------------------------------------|-----|-----------------|------------------------|------------------------------------|-----|-----------------|------------------------|
| Please Use ID Label or Block Print |     |                 |                        | Please Use ID Label or Block Print |     |                 |                        |
| SURNAME                            |     | UNIT RECORD NO. |                        | SURNAME                            |     | UNIT RECORD NO. |                        |
| GIVEN NAME                         |     | CHINESE NAME    |                        | GIVEN NAME                         |     | CHINESE NAME    |                        |
| SEX                                | AGE | WARD            | ADMITTED DATE AND TIME | SEX                                | AGE | WARD            | ADMITTED DATE AND TIME |
| ATTN. DOCTOR:                      |     |                 |                        | ATTN. DOCTOR:                      |     |                 |                        |
| CONSULT. DOCTOR:                   |     |                 |                        | CONSULT. DOCTOR:                   |     |                 |                        |

(1)A 本人 I \_\_\_\_\_ \*身份证号码 / 护照号码 在此同意  
 (病人姓名 Name of Patient) \*H.K.I.D.No. / Passport No. \_\_\_\_\_ hereby voluntarily

接受 give my consent to undergo the procedure of \_\_\_\_\_ ,  
 (手术名称 Name of Procedure)  
 由 to be performed by Dr. \_\_\_\_\_ 医生施行，并使用 \*全身麻醉 /  
 under \*general anaesthesia /  
 区域麻醉 / 局部麻醉 / 静脉注射镇静剂 / 监测麻醉 / 无麻醉方式。  
 regional anaesthesia / local anaesthesia / intravenous sedation / monitored anaesthetic care / no anaesthesia.

或 OR

(1)B 本人 I \_\_\_\_\_ \*身份证号码 / 护照号码 为病人  
 (签署者姓名 Name of Signatory) \*H.K.I.D.No. / Passport No. \_\_\_\_\_ am patient

的 \*父亲 / 母亲 / 监护人，在此代表病人同意接受  
 's \*father / mother / guardian, hereby voluntarily give my consent for the Patient to  
 (病人姓名 Name of Patient)  
 undergo the procedure of \_\_\_\_\_ 由 to be performed by  
 (手术名称 Name of Procedure)  
 Dr. \_\_\_\_\_ 医生施行，并使用 \*全身麻醉 / 区域麻醉 / 局部麻醉 /  
 under \*general anaesthesia / regional anaesthesia / local anaesthesia /  
 静脉注射镇静剂 / 监测麻醉 / 无麻醉方式。  
 intravenous sedation / monitored anaesthetic care / no anaesthesia.

(2) 本人确认，在签署此同意书前，已获得有关此手术/医疗程序之资料，包括：  
 I acknowledge that, before signing this consent form, I have been fully informed about the proposed Procedure, including the following:

- (a) 需要进行是项手术 / 医疗程序之原因  
Indication for performing the Procedure.
- (b) 是项手术 / 医疗程序之性质  
General nature of the Procedure.
- (c) 是项手术 / 医疗程序可能引致的危险及并发症，包括但不限于出血、伤口感染、肺炎、其它感染、心脏病发、中风、大腿静脉栓塞、肺血管栓塞、以及死亡  
Potential general risks of complications and side effects, including but not limited to bleeding; wound infection; chest infection; other infection; heart attack; stroke; blood clot in the leg veins; blood clot travelling to the lungs; and death.
- (d) 是项手术 / 医疗程序及与病人情况有关之潜在危险及并发症  
Potential specific risks of complications and side effects relevant to the Procedure and the Patient's condition.
- (e) 其它治疗方法及不接受治疗所带来的后果  
Other treatment options, and consequences of no treatment.
- (f) 是项手术 / 医疗程序在进行中或完成后可能需要的额外治疗 / 手术，包括：  
Additional and/or consequential treatment(s) or management which may become necessary during or after the Procedure including:  
 深切治疗 intensive care;  
 输血 blood and blood products transfusion (已提供资料 Information leaflet provided  是 Yes  否 No);  
 由微创转为开腔手术 conversion to open procedure from minimal invasive procedure.

請 ✓ 适用项目及/或列明其它适用之治疗  
 Please tick box if applicable, and/or insert other treatment or management, if appropriate \_\_\_\_\_

NUA-345-11-2419sc(R4)

Consent for Surgical / Invasive Procedure

### 接受手术 /

### 介入性医疗程序同意书

### Consent for Surgical / Invasive Procedure

|                                    |     |                 |                        |                                    |     |                 |                        |
|------------------------------------|-----|-----------------|------------------------|------------------------------------|-----|-----------------|------------------------|
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| GIVEN NAME                         |     | CHINESE NAME    |                        | GIVEN NAME                         |     | CHINESE NAME    |                        |
| SEX                                | AGE | WARD            | ADMITTED DATE AND TIME | SEX                                | AGE | WARD            | ADMITTED DATE AND TIME |
| ATTN. DOCTOR:                      |     |                 |                        | ATTN. DOCTOR:                      |     |                 |                        |
| CONSULT. DOCTOR:                   |     |                 |                        | CONSULT. DOCTOR:                   |     |                 |                        |

#### 3. 本人明白

I understand that

- (a) 如有需要，除上述医生外，可能需要其它医生参与是项手术 / 医疗程序；  
by necessity, medical practitioners other than the Doctor may assist in performing the Procedure;
- (b) 若在手术期间有身体器官或组织被切除，这些器官或组织可能被弃置，或先作病理检验，然后被弃置；  
if tissues or organs are removed during the Procedure, they may be submitted for pathological examination following which they will be disposed of appropriately, or they may be disposed of without such pathological examination;
- (c) 是项手术 / 医疗程序可能会被摄像或录像以作存档或教学用途，如属后者，病人之身分将不会被公开或识别；及  
during the Procedure, photographs or other recording may be taken which may be used for medical documentation or teaching purposes. For the latter, the Patient's identity will not be disclosed or identifiable; and
- (d) 进行是项手术 / 医疗程序，并不保证病人情况或以后病况会改善。  
there is no guarantee that the Patient's condition or prognosis will improve following the Procedure.

4. 在施行是项手术期间，如医生认为应作进一步的手术，或须施行另一项手术，本人亦同意进行。  
I also consent to further or alternative operative measures as may be found to be necessary or advisable during the course of such operation.

5. 若是进行绝育手术，本人明白手术后可能仍有生育能力。  
If the procedure is for the purpose of my sterilization, I understand that there is a possibility that I may not remain sterile after the sterilization procedure.

6. 本人确认收到有关是项手术/医疗程序的资料(附页)，并已阅读及完全明白其内容 ( 是 / 否)。  
I confirm that I have been provided with an information leaflet on the Procedure (copy attached), and that I have reviewed the same, and that I fully understand the contents ( Yes / No).

\*病人/父母/监护人签署

Signature of \* Patient / Parents / Guardian : \_\_\_\_\_ 日期 Date: \_\_\_\_\_  
DD/MM/YYYY

见证人签署

姓名

日期

Signature of Witness: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(请用正楷填写 Name in BLOCK LETTER) DD/MM/YYYY

医生声明：本人已向上述签署者解释是项手术/医疗程序的性质、风险及效益，并已解答其提出的有关问题。据本人所理解，上述签署者已获得充分的资料及已签妥同意书，而这些资料亦已记录在病人的病历内。

DOCTOR'S DECLARATION: I have explained the nature, risks and benefits of the operation to the above signatory and have answered the above signatory's questions. To the best of my knowledge, the above signatory has been adequately informed and has consented, and the details as such had been documented in the Patient's clinical record.

负责手术之医生签署

日期

Signature of Doctor responsible for the procedure: \_\_\_\_\_ Date: \_\_\_\_\_  
DD/MM/YYYY

由翻译员填写(如适用)：

To be completed by Interpreter (if applicable) :

本人

已如实地及清楚地

I \_\_\_\_\_ certify that I have truly, distinctly and audibly interpreted the

将此同意书的内容翻译成

向签署者传译。

contents of this document into \_\_\_\_\_ to the Signatory.

(语言或方言 insert language or dialect)

翻译员签名

日期

Signature of Interpreter: \_\_\_\_\_ Date: \_\_\_\_\_  
DD/MM/YYYY

\* 请删除不适用句子 Delete if inappropriate.