Patient Agreement to Investigation or Treatment

Patient Details or Label

This treatment/procedure information document prepared for

Family name	Hakami
First name	Abdullah
Date of birth	19.08.1995
Age	26 years
Gender	M
File number	1076910
Responsible health professional	Dr. Hamad Albagieh
Job title	Consultant- Oral Medicine
Special requirements	None

To be retained in patient's notes

Name of proposed procedure or course of treatment
(Include a brief explanation if the medical term is not clear)

Extra- and intra-oral examination, x-rays, excisional biopsy, sutures, histopathological analysis

Statement of health professional (to be filled in by health professional with appropriate knowledge of the proposed procedure, as specified in consent policy)
I explained the procedure to the patient. In particular, I have explained:

The intended benefits: __Diagnosis of the rapidly growing pigmented lesion in the oral cavity

Unavoidable, serious, or frequently occurring risks ____bleeding, discomfort, pain, infection

☐ Blood transfusion _____

☐ Other procedure (please specify) _____

I acknowledge that I have been provided a treatment/procedure information document prepared for me. This document outlines the general treatment considerations, potential risks, and hazards associated with my treatment. I, also, understand that there may be potential hazards and risks not described in the treatment/procedure information document. I have had the opportunity to discuss and clarify treatment considerations and risks with **Dr. Hamad**. The prescribed treatment was explained to me on 15.05.2019. I authorized student(s), resident(s), and/or faculty of the University School of Dentistry to provide the outlined treatment. I further understand that, like the other healing arts, the practice of dentistry is not an exact science and that, therefore, not all complications can be predicted, and treatment results cannot be guaranteed.
Any extra procedures which may become necessary during the procedure.

Patient's Bill of Rights
The students, faculty, and staff of Exam Group School of Dentistry strive to provide high quality treatment/procedure in a patient-friendly atmosphere. As our patient, you have a right to the following:

- Comprehensive treatment that meets professional standards of care.
- Clear explanation of recommended and alternative treatment options, the risk of such treatment options, and the risks of no care.
- Current information about the status of your oral/dental health and progress of care.
- Accurate information about costs prior to the proposed treatment.
- Treatment with respect, consideration, and confidentiality.
- The right to ask questions about your oral/dental care at any time.
- Access to a patient representative for assistance
- Adequate information as needed to be able to give consent to proposed procedures
- Confidentiality regarding your medical conditions, oral health, and records.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), and any concerns of this patient.

☐ The following leaflet/tape has been provided

This procedure will involve:
☐ General and/or [redacted]

[redacted] Date: 15.05.2019

Name: Dr. Hamad Albagieh

Job title: Consultant-Oral Medicine

Contact details (if the patient wishes to discuss options later)

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.
Signed_____ Date_____

Name _____

Statement of patient
Please read this form carefully. If the procedure has been planned in advance, you should have had the risks and benefits and any alternative treatments described to you. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

[x] **I agree** to the procedure or course of treatment described on this form.

[x] **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

[x] **I understand** that I will have the opportunity to discuss the details of anesthesia with an anesthetist before the procedure unless the urgency of the situation prevents this. (This only applies to patients having general or regional anesthesia.)

[x] **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

[x] **I have been told** about additional procedures, which may become necessary during my treatment.
I have listed below any procedures, which **I do not wish to be carried out** without further discussion.

Signature_____ [redacted] _____ Date: 15. 05.2019

Name _ Abdullah Hakami

OR, I THE PATIENT REFUSED INFORMATION ABOUT TREATMENT

Signature _____ Date: _____

Name _____

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure if the patient has signed the form in advance)
On behalf of the team treating the patient, I have confirmed with the patient has no further questions and [redacted]

[redacted] Date 15.05.2019

Name ___ Dr. Hamad Albagieh _____Job title ____Consultant-Oral Medicine

Important notes: (tick if applicable)
☐ See also advance directive/living will

Agreement for research purposes:

I, __Abdullah Hakami _ authorize a dentist/oral medicine specialist to take photographs, radiographs, dental impressions or any necessary diagnostic aids to make a complete diagnosis for the patient.
I consent to allow my medical information, photographs, x-rays to be used for dental records, oral/dental health research, and oral/dental health education including lectures, and [redacted]

[redacted] Date___15.05.2019_

Name__ Abdullah Hakami