Medical Treatment Consent Form

_____

[Name of the medical center / hospital / nursing home/clinic/ or doctor]

Location: _____

Phone: _____

From: _____ [Give the name of the hospital, clinic or doctor]

Date: _____

Subject: _____ [Give the appropriate subject of the topic e.g.; regarding the consent for medical treatment for the patient _____ (give the name of the patient whose treatment needed to be done)]

As you are aware that _____ [Mr. / Mrs. / Ms] _____ [mention the name of the patient] is suffering from _____ [mention the name of the disease or illness]. So we would want to undertake his treatment at the earliest.

We would request your consent for the medical treatment of the patient so that we can help him as soon as possible. The treatment would involve the following:

Surgeries (if any): _____

Tests (if any): _____

We would request you to give your consent for all these surgeries and procedures. Please also note that cost that will be incurred in the whole treatment procedure.

Total cost to be incurred: _____

Surgery 1: _____ [Each for each surgery separately]

Surgery 2: _____

Test 1: _____ [Each for each test separately]

Test 2: _____

I, _____ [mention the name of the responsible party], agree to all the terms and conditions of the above document. I request you to proceed with the appropriate treatment procedures so that the patient can become well soon.

_____ [Signature of the dependent]

_____ [Relationship of the responsible party for the patient]