Professor Roger Allen Medical

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BRONCHOSCOPY PROCEDURE CONSENT FORM

Name: ______________________________ **Date of Birth:** __________________

Procedure Date: ______________________________

I, the undersigned, request the above procedure to be performed on me by Professor Roger Allen. I also request the administration of anaesthetics, medicines or other forms of treatment normally associated with this procedure.

I acknowledge that Professor Roger Allen has informed me of all aspects of this procedure and any post-operative complications that may arise from my surgery or anaesthetic. Although this procedure will be carried out with all due professional care and responsibility, I understand that in some circumstances the expected result may not be achieved and accept the possible risks associated with this procedure.

I have had the opportunity to ask questions about the procedure and am satisfied with the information received. I have informed Professor Roger Allen of an accurate medical history and/or any prior health issues that may impact on this surgery.

I, the undersigned, consent to this procedure.

Name: ______________________________

Address: ____

Signature: ____________________________

Date: ________________________________

I, Professor Roger K A Allen, have discussed with Patient, their present condition, alternative treatments available and explained the benefits and risks of the above procedure.

Professor Roger KA Allen
Thoracic & Sleep Physician