



dr. louis hofmeyr

## Consent to medical treatment or procedure

Date \_\_\_\_\_

1. I, \_\_\_\_\_ ID \_\_\_\_\_

hereby give my consent to the performance of the following procedures:

1. \_\_\_\_\_

2. \_\_\_\_\_

by Dr LM Hofmeyr on myself/my dependant/my child.

Name of patient \_\_\_\_\_

2. Dr LM Hofmeyr has provided me with a general explanation of the reasons for the procedure/s, the indication, the nature and the implication of this specific procedure/s, as relating to my particular medical condition. Dr LM Hofmeyr has also discussed with me the possible risks and the benefits of the procedure/s, including possible alternatives. Dr LM Hofmeyr has also explained the anticipated recovery time and aftercare to me.
3. Dr LM Hofmeyr has provided me with the information leaflet of the procedure/s. I have had the opportunity to study this and to ask questions. I was informed that it may not cover all aspects and that on my request more information could be supplied.
4. I grant consent to any radiological or diagnostic examination/laboratory tests/hospital services that are medically indicated and that may be prescribed.
5. Dr LM Hofmeyr explained to me that other physicians and/or healthcare providers may participate in my care. I therefore extend this authorization to these physicians and healthcare providers. Although unlikely in the event that my physician is not available to perform the above-mentioned operation/procedure/treatment/process/aftercare I understand that this authorization will be extended to an available colleague and will I be notified of the substitution.
6. Please note that Dr LM Hofmeyr will not be responsible for any claims arising from maltreatment or negligence caused by the hospital, its employees or representatives, or any partaking physicians or healthcare personnel.
7. I understand that I am responsible for the surgical fees as provided to me.

**Dr. LM Hofmeyr**  
OTOLOGIST AND NEUROTOLOGIST  
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8. I consent to a blood/blood product transfusion upon the instruction of the attending medical practitioner.
9. I consent to the incineration of all human tissue/bone that is removed during the above-mentioned procedure/s.
10. I consent that Dr LM Hofmeyr is allowed to record my procedure/s or part thereof and to use it as well as my other information for documentation, training, teaching or presentations and that my identity will not be revealed in any way through this process.
11. I consent to the fact that other health care professionals may be present during my procedure/s to observe or assist.
12. Should my medical condition that has been diagnosed change prior to the procedure/s and after consenting I have the obligation to disclose this information to Dr LM Hofmeyr as this can affect treatment and outcome.
13. After discussing all the above Dr LM Hofmeyr gave me the opportunity to ask questions and seek further information. I believe that I do not require further information at this time and I am prepared to proceed with the recommended procedure/s. I believe that Dr LM Hofmeyr has honoured my right to make my own informed health care decision. I give my consent voluntary and freely, and certify that I legally can give valid consent. I understand that I can revoke this consent at any time until such time of the procedure/s process started.
14. I declare that the above information was supplied in a language that I understand.

Signed at \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Signature \_\_\_\_\_

Name \_\_\_\_\_

Capacity of above signatory \_\_\_\_\_

(See section 7 National Health Act, 2003(Act 61 of 2003))

Patient's  
signature \_\_\_\_\_

As Witness \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_