DR. BEYERS OOSTHUIZEN

MIDSTREAM ORTHOPAEDICS

MBCHB (PRET), MMED (ORTH)(PRET), FCORTH (SA)

CONSENT FOR SURGERY

I,……hereby give my consent for the performance of the following procedure on me/my dependent. I confirm that Dr PB Oosthuizen has provided me with the general explanation of the nature of this operation and the reasons why it is indicated for my/the patient's medical condition. Dr Oosthuizen has discussed the **risks and benefits of the operation** including alternatives.

Procedure:……

Specific Risks:……

I/We acknowledge that some of the **serious and common complications** listed above were discussed and are aware that this is not a full list and other unforeseen adverse events could occur.
I hereby grant consent to any **hospital and other health care services** that are medically indicated or that the doctor may prescribe or require including any surgery, radiology, diagnostic examination, anesthetic, blood or blood product infusion, or laboratory tests (**including an HIV test in the event of a needle-stick injury to one of the healthcare team**) for me/the patient.
I consent to the presence of a **company representative** should the doctor elect that he/she be present in theatre. It is understood that the company representative advises the theatre staff on his/her company's medical devices to be used. I consent to the taking of **photographs and collecting or using clinical information** for clinical/research/registry purposes only. I understand that the doctor will not use these photographs or information in any manner that will identify me.

After discussing the above, the Dr Oosthuizen gave me an opportunity to ask questions and seek further information. I do not require further information and I am prepared to consent to him proceeding with the recommended operation. I believe that the doctor has honored my right to **make my own informed health care decision**. I give my consent voluntarily and freely and certify that I can give valid consent. I understand that I can revoke my consent to the operation at any time up until the time the operation process has started. I also consent to my/the patient's personal information including information relating to my/the patient's health and treatment being processed or given to any person necessary in relation to the operation and related treatment and payments due.
In the event of allegations of negligence, I agree to **embark on mediation** prior to embarking on litigation.

……	……	……
PATIENT / GUARDIAN	DATE	ID number

PR Number: 0520713 | MP Number: 0629472

info@midstreamortho.co.za www.midstreamortho.co.za

Mediclinic Midstream Hospital, Suite 112, Midstream Hill, Midstream, 1692 +27 12 652 9431

Netcare Unitas Hospital, Suite 315, Lyttleton, Centurion, 0157 +27 12 664 4240

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AUTH NUMBER:

PROCEDURE INFORMATION

Instrumentation:.....

Procedure codes:.....

ICD 10 Codes.....

Procedure date.....

Practice numbers:	**0520713**	**0579068**	**5808138**
	Dr PB Oosthuizen	**Mediclinic Midstream**	**Netcare Unitas**

Important information:

1. **Kindly pre-book your bed at the hospital reception, online or be phoning pre-admissions at the relevant hospital.**
2. **Stop eating or drinking 22h00 the night before surgery**
3. **Report to hospital reception 06h00 the day of surgery**
4. **Bring along:**
   - **All relevant X-Rays, Ultrasound report, CT scan, MRI scans in your possession**
   - **ID Document, Medical Aid details, Authorization number**
   - **Items of a personal nature**
   - **Chronic medication**

CONSENT TO FEES BEING CHARGED BY THIS PRACTICE

I, the undersigned, do hereby:

- Acknowledge that I have been informed that this practice does not charge the rates that the Department of Health has recommended for doctors and which are known as the Reference Price List (RPL)
- Confirm that I am aware that this practice fees are charged at **RPL x 217%** unless otherwise contracted.
- The RPL values for services are available from the Department of Health (012-312-0000) and the Health Professions Council of South Africa (012-338-9300) and www.doh.gov.za
- Accept that although I am a member of a medical scheme, I remain fully responsible for payment of the doctor's account until fully paid. The doctor's services and his contract are with me as the patient and not with the medical scheme.
- Confirm that, should I not pay timeously, I will be liable for payment of legal fees (including but not limited to tracking costs and collection fees) on attorney and own client scale.
- Acknowledge that an account older than 4 months will not be settled by the medical scheme and I will be held responsible for the settlement of the account
- I/we the undersigned, hereby confirm that the practice may use the patient information provided to the hospital/practice for communication purposes on the accounts.
- Give permission for the use of ICD-10 codes for more effective account payment by the medical scheme.
- Acknowledge that I/the patient may be responsible for **co-payments** for any orthopedic prosthesis/implants, bone graft/substitutes required, hospital co-payments or any other expenses that are not covered by my Medical Aid.

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