Republic of the Philippines
Department of Health
Center for Health Development Davao Region
SOUTHERN PHILIPPINES MEDICAL CENTER
Davao City

SPMC-F-MRI-22

REQUEST FOR SURGERY

[ ] EMERGENCY [ ] PHIC [ ] ELECTIVE
*[ ] Exigent (w/in 1°) [ ] Service
*[ ] Emergent (w/in 6°) [ ] Pay____PC____HC
*[ ] As soon as prepared
* Estimated length of Operation: ________

Date & Time Requested: ________
Ward: ________ Requesting NOD: ________
Date & Time Received: ________
O.R. NOD: ________

Patient: ________ Age: ____ Sex: ____ HRN: ________
Diagnosis: ________
Operation Procedure: ________

Surgeon: ________ Date of Operation: ________
Anesthesiologist: ________ Time of Operation: ________

SPECIAL REQUIREMENTS:

[ ] CP Clearance [ ] Pedia Clearance
[ ] Pulmo Clearance [ ] Others, pls specify _________
[ ] Consent

Clearance from Billing/ Cashier: ________
OR# ____ Amount Deposited: ________

*Requested by SROD/Surgeon: ________ Remarks: ________

Note * To be filled up by the surgeon

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Effectivity: August 7, 2014 **Revision: 1** **Page 1 of 1**

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SOUTHERN PHILIPPINES MEDICAL CENTER

Davao City

SPMC-F-MRI-21C

AUTHORIZATION FOR PERFORMANCE OF OPERATION AND OTHER PROCEDURES

TO WHOM IT MAY CONCERN:

I, ______________________________ __________ years of age ________________

(Family Name) (First Name) (M.I.) (Age) (Relationship)

hereby consent to have ____

____

(please specify procedures)

performed upon____ by any member of the hospital staff of the *SOUTHERN PHILIPPINES MEDICAL CENTER*, Davao City. Be it known that this consent was voluntary and given without influence or intimidation by anybody after duly understanding the necessity and risk of such procedures operation and / or treatment.

I further consent to the ADMINISTRATION or such anesthesia as may be considered necessary or desirable in the judgement of the Medical Staff of the same hospital.

I further consent to the disposal by authorities of the above named hospital of whatever tissues or parts that may be deemed necessary to remove.

I also consent to the taking of photographs in the course of the treatment or operation for the purpose of advancing medical knowledge only with utmost confidentiality.

Be it known further that whatever the result of the intervention or treatment to be done, NONE WILL be liable or responsible to any charge that my family, guardian or relative may claim.

____________________ Date

____________________ Signature or Thumbmark of patient or person authorized to consent for operation

WITNESS:

____________________ Signature over Printed Name

____________________ Signature over Printed Name

INTERPRETER IF REQUIRED:

____________________ Signature over Printed Name

Date	Operation or Procedure	Signature of patient or person giving consent	Witness preferably relative