# ST KYROLLOS FAMILY CLINIC

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## PATIENT CONSENT FOR MINOR SURGERY

**I/We, MR/MRS/MISS/MS_____**

**Give Consent To Dr Ashraf E Saddik To Perform The Following Procedure: __Circumcision__**

**On Myself Or For The Following Nominated Person (Name):**

**(Of the Son / Boy named) _____**

**Aged _____Weeks/Months / years hereby consent on his behalf to undergo the circumcision.**

**Dr. Saddik has explained it to me the nature and effects of the circumcision and given detailed information and operative care sheets.**

**I consent to the administration of the appropriate anesthetic/analgesia/light sedation and postoperative pain-relief as needed.**

**I give consent to Dr Saddik to perform surgery and proceed with any further treatment, required.**

**_____ _____**
**PATIENT'S SIGNATURE OR the (Guardian / Parents / Father/Mother) SIGNATURE**

**DATE_____**

**WITNESS NAME (PRINT)**

**_____**

**The (Guardian / Parents / Father / Mother)**
**Of the Son / Boy named _____**
**Aged _____Months / years, hereby consent on his behalf to undergo the circumcision.**
**Dr. Saddik has explained it to me the nature and effects of the circumcision.**
**I also consent to the administration of the appropriate anesthetic and postoperative pain-relief. .**