

PATIENT'S CONSENT FORM

PATIENT'S AGREEMENT TO TREATMENT

FORM 1**STEM CELL THERAPY FOR PERIPHERAL VASCULAR DISEASE**

This form must be completed by the attending Physician (in BLOCK LETTERS)

PATIENT'S PARTICULARS		
Name as per NRIC or Passport :	Age: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Correspondence address :		
Patient's Signature:	Citizenship(Country) :	
	Tel (O): Fax :	
NRIC No / Passport No.:	H/P : Email :	
PATIENT'S STATEMENT		
1.	I understood the purpose and mode of treatment.	
2.	I am satisfied with answers for my questions.	
3.	I am satisfied with the procedures for my treatment.	
4.	I am agreeable to undergo for Peripheral Vascular Disease.	
5.	I understand that the Isolation of my bone marrow will be done at NiSCCELL	
6.	I understand that if the cells after Isolation are found to be unsuitable for transfusion for any reason, they will not be transfused to me and the procedure will have to be repeated at patient's cost.	
7.	I was informed of the probable adverse reactions.	
PATIENT'S DECLARATION		
<ul style="list-style-type: none"> • I have understood the contents of this Consent Form. <input type="checkbox"/> • I consent to the treatment of my Peripheral Vascular Disease. <input type="checkbox"/> 		
SIGNATURE OF PATIENT /GUARDIAN :		
DATE :		

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*PARENT/SPOUSE/ NEXT OF KIN'S PARTICULARS		
<i>(* Cancel those are not applicable)</i>		
Name as per NRIC or Passport:	Age : DOB :	Male <input type="checkbox"/> Female <input type="checkbox"/>
Correspondence address :		
NRIC No / Passport No.:	Citizenship (Country):	
	Tel (O):	Fax :
Email :	Tel (Hse) :	H/P:
Date :	Signature :	
ATTENDING PHYSICIAN		
Physician's Name :	Tel(o):	fax:
	(H/P):	Email:
NRIC. Number :	Name & Address of hospital :	
Physician's Signature:		
Date:		