Coma Recovery Scale

Patient Name: _____ Date of Birth: _____

Date: _____ Practitioner: _____

PATIENT ACKNOWLEDGEMENT

- [ ] I consent to the proposed treatment or procedure as described
- [ ] I have been informed of the potential risks, benefits, and alternatives
- [ ] I have had the opportunity to ask questions and received satisfactory answers
- [ ] I confirm that my medical history provided herein is accurate and complete
- [ ] I understand I may withdraw my consent at any time before the procedure begins
- [ ] I acknowledge that results cannot be guaranteed and may vary between individuals

ADDITIONAL INFORMATION

Allergies or Contraindications: _____

Current Medications: _____

Special Requirements: _____

AUTHORISATION

Patient Signature	Practitioner Signature	Date