Electronic consent form

Informed consent to treatment · generic template for any practice to adapt

How to use this template. Replace the prompts in each section with your own procedure wording, then add your practice name, logo and retention policy. Have your medical director review the finished form, and check the signature and co-signature rules that apply in your state or country. This template is a starting point for documentation, not legal advice.

1 PATIENT IDENTIFICATION

Every consent record must be traceable to one patient, one practice and one date.

Patient full name _____ **Date of birth (dd / mm / yyyy)** _____

Medical record number _____ **Contact number** _____ **Email address** _____

Practice name and location _____ **Treating clinician** _____ **Date of this consent** _____

2 PROCEDURE OR TREATMENT DESCRIPTION

Write it in plain language: what will be done, where, with what, and how long it takes.

Procedure or treatment _____ **Area or site treated** _____ **Sessions planned** _____

Products, devices or medicines used _____ **Anesthesia or pain relief** _____ **Expected time in the practice** _____

What will happen, step by step

_____

_____

_____

3 RISKS AND BENEFITS

List common, uncommon and rare risks, with published frequencies where you have them.

Known risks and side effects _____ **Expected benefits and likely result** _____

_____ _____

_____ _____

_____ _____

☐ The risks and benefits above were explained to me, and I had the chance to ask about each one. Patient initials _____

4 ALTERNATIVES DISCUSSED

Record every option the patient could have chosen instead, including doing nothing.

Alternative option	What it involves and why it was not chosen	Discussed
		☐
		☐
No treatment at this time		☐

5 CONTRAINDICATIONS AND SCREENING

Answer every row. Give details below for anything marked yes or unsure.

Screening question	Yes	No	Unsure
Pregnant, planning a pregnancy, or breastfeeding	☐	☐	☐
Known allergy to medicines, latex, anesthetic or topical products	☐	☐	☐
Bleeding disorder, or taking an anticoagulant or antiplatelet medicine	☐	☐	☐
Taking any prescription or over-the-counter medicine or supplement	☐	☐	☐
Active infection, or a skin or tissue problem at the treatment site	☐	☐	☐
Previous reaction or complication after a similar treatment	☐	☐	☐
Other relevant history, such as autoimmune, cardiac or neurological conditions	☐	☐	☐

Details for any yes or unsure answer

_____

Clinician screening outcome: ☐ Suitable to proceed ☐ Proceed with modification ☐ Deferred or not suitable

6 PATIENT CONSENT AND ELECTRONIC SIGNATURE

I confirm that the procedure named in section 2 has been explained to me in language I understood. I have read the risks, benefits and alternatives set out above, and my questions have been answered. I understand that no result is guaranteed, and that further treatment may be needed at additional cost. I understand that I can withdraw my consent at any point before the treatment starts. I agree that my electronic signature carries the same weight as a handwritten one.

☐ I have read and understood this form ☐ My questions have been answered ☐ I consent to the treatment described
☐ I consent to clinical photographs for my record (optional) ☐ I have been given a copy of this form

Patient name, typed

Date and time signed (dd / mm / yyyy, hh:mm)

Patient electronic signature

Signed on (phone, tablet, in-practice device)

How the form was sent

☐ In practice ☐ Email
☐ SMS ☐ Patient portal

Audit reference or IP address

If signed by a parent, guardian or representative — full name

Relationship to the patient

Authority to sign (power of attorney, parental responsibility)

7 CLINICIAN CONFIRMATION AND CO-SIGNATURE

I confirm that I explained the treatment, its risks, benefits and alternatives in terms the patient understood. I screened for the contraindications listed in section 5, answered the patient's questions, and I am satisfied that consent was given voluntarily.

Treating clinician name

Role and license or registration number

Clinician signature

Date and time (dd / mm / yyyy, hh:mm)

Co-signature below where a medical director, prescriber or supervising clinician must countersign. Check the rule for your state, country and specialty before you remove this block.

Co-signing clinician name and role

License or registration number

Co-signature

Date and time (dd / mm / yyyy, hh:mm)

NOTES AND RECORD KEEPING

Retention. File the signed form against the patient record and the appointment it covers, with the timestamp and signing metadata kept alongside it. Follow your own retention schedule and the privacy law that applies to you, such as HIPAA in the United States or UK GDPR in the United Kingdom. Electronic signatures are recognized federally under the E-SIGN Act and at state level under UETA, provided the record shows who signed, when, and what they agreed to.

Template supplied by Pabau for practices to adapt. Edit the wording to match your own procedures and local rules before you use it with patients. It is not legal advice.