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**SINGAPORE THONG CHAI MEDICAL INSTITUTION**  
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Reg No. 196000175E

**SINGAPORE THONG CHAI MEDICAL INSTITUTION**  
**CONSENT FOR PATIENT TO UNDERGO ACUPUNCTURE TREATMENT**

Name of Patient:	Date of Birth:
Male / Female:	
Tel:	NRIC No:

I, undersigned, hereby declare that I understand the therapeutic function and clinical effect of acupuncture treatment and am fully aware of the discomfort which may arise in the course of the acupuncture treatment or when the said treatment is completed. I am willing to undergo this treatment

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Guardian's Signature

\_\_\_\_\_  
Duty Physician's Signature

I/C No, \_\_\_\_\_

(Guardian's Signature is required for patients under 21 years of age)



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If the patient willing to undergo acupuncture treatment is suffering from any hidden condition, it must be disclosed to the physician: This measure is strictly confidential; the patient's name shall never appear in any medical literature which may be published. The medical case in question shall be used for the purposes of academic research and reference only.

(Please mark the box  with a tick "✓")

- |   |                              |                             |                                   |
|---|------------------------------|-----------------------------|-----------------------------------|
| (1) Heart Disease                             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (2) Diabetes                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (3) Hepatitis                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (4) Skin Disease                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (5) Cancer                                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (6) Venereal Disease                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (7) AIDS (Acquired Immunodeficiency Syndrome) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (8) Convulsion                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (9) Abnormal Bleeding                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (10) Thrombocytopenia (Low Platelet Count)    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (11) Tuberculosis                             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (12) Kidney Disease                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (13) Influenza                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (14) Pregnancy                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |
| (15) Others: .....                            | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Not Sure <input type="checkbox"/> |

If you have any enquiries, please consult your physician.