CONSENT FORM
FOR MEDICAL EXAMINATION, TREATMENT OR SURGERY

Patient's Personal Information	Hospital or Clinic
Name:……..	……
Surname: ……	
Address:……..	……
Date of Birth:……..	
Sex Male: Female:	

DOCTOR: (to be filled by the doctor) (See notes on 2nd page).

Kind of surgery, examination or treatment for which written signed proof of consent is needed:
……
I assure that I have explained to the patient the surgery, examination or treatment and the existing alternative procedures & the type of anesthesiology if mentioned (general, local, sedation) the possible complications that might occur, with a way that according to my knowledge is understandable to the patient.

Signature……
Date……
Doctors Name……

(Presence of a witness if needed)
Signature……
Witness's Name……..

PATIENT:

1. Please read this form and the back notes carefully.
2. If there is anything you do not understand from the explanation or you need more information you will have to ask the doctor.
3. Please make sure if all the information of the form are correct. If yes, and you understood the explanation that was given to you, singed the form.

I am the patient……..

I declare

A. That the doctor has explained to me in detail the kind of the surgery, the risks, the advantages and the alternative solutions of this treatment.

B. That I understand fully the explanations that were given to me regarding the nature, the advantages and the purpose of the surgery, treatment and other procedures, the possible risks, the alternative solutions and the possible complications that might occur.

I agree

A. To what it is proposed, which was explained to me by the doctor stated above.
B. To the usage of anesthetic that was mentioned to me.
C. To the joining of medical students or medical practitioner doctors under supervision. (Delete if not needed). **Yes…… No……**
D. To the blood transfer or other blood substances. **Yes….. No……**

I acknowledge

A. That during the surgery, treatment or other procedures it will be possible that unpredicted event might occur.

B. That no absolute guarantee is given as far as the outcome is concerned.

C. That any additional procedure to the research or treatment that is being described to this form will be held only if its necessary and to the interest of my health and can be justified for medical reasons.

I have mentioned

To my doctor if I suffer from any contagious disease and I have not hide anything as far as my medical background is concerned.

Signature.....

Date.....

In case of a minor patient (under 18 years of age) or in case where the patient is not in a position to consent for the reason of.....		
.....	.....	.....
Witness	Signature of an authorized person to consent	Relation with the patient

NOTES FOR:

DOCTORS:

- The patient has the legal right to fill in the concern form before the examination or treatment. The patients have to be given clear information with an understandable to them way, as far as the suggested treatment and the possible alternative solutions. The patients must be left to decide if they agree to the treatment and can refuse or withdraw their concern form for treatment whenever. The patients' consent for treatment has to be written on this form.

PATIENTS:

- The doctor is here to help you. He/She will explain to you the suggested treatment and which are the alternative solutions. You may ask any questions you want and you can also ask for more information. You can also refuse the treatment.
- You can ask for the presence of a relative or a friend or a nurse.
- The education of health professionals is needed for the maintenance and progression of the health services and it also improves the quality of treatment. Your treatment can provide an important chance for such education and where it is needed under the supervision of an experienced doctor. You can refuse any involvement with a formal educational program without an impact to your level of care and treatment.

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