

Version No.	1.0	Valid from	June 2016
Document number	DC435	Unit	Medical

INFORMED CONSENT FOR SURGERY/ PROCEDURE/ EXAMINATION/TREATMENT

TO BE COMPLETED AND SIGNED BY THE PHYSICIAN AND PATIENT

Dear patient,

Please read the following informed consent statement carefully and confirm by placing your name and signature.

I, the undersigned,(last name, first name)

as the patient / parent / legal representative (delete as appropriate) of the patient:(last name, first name)

- Agree to the suggested surgery/ high-risk examination/ treatment/ procedure, being: left right bilateral N/A
 - If this surgery/procedure/examination relates to the transplant/ donation of ocular tissues tissues of the locomotor system

I consent to the physician performing the above surgery/procedure/examination
I have been given the opportunity to ask questions.

- I have been given sufficient information about the risks, benefits and alternatives relating to the surgery/high-risk examination/ treatment/ procedure. I have fully understood this information. I obtained this information from
 - website
 - information sheet/brochure
 - verbal information from a care provider:
 - risks:
 - benefits:
 - alternatives:
 - other:

- I declare that I will comply with all of the guidelines of the physician regarding the suggested surgery/ examination / treatment/ procedure. I realise that in spite of the best efforts and care on the part of the treating physician (s), the nursing team and myself, success cannot be absolutely guaranteed.

- I agree that in case of emergency, all measures should be taken to ensure my safety/health.
 - except for:.....

- I consent that before/during/after the abovementioned surgery/procedure/examination anonymous images or pictures may be taken, which, together with some information from the record, can subsequently be used for medical education or scientific publication.

Signature patient/representative:

Date: / / | Time: h

Physician's name:

Date: / / | Time: h