(Fill out in the absence of label)

Hospital Name _____

Full Name: _____

Date of birth: ___/___/_____ Age: _____ Gender: _____ Bed: _____

Admission Date: ___/___/_____ Time: _____ Registration: _____

Chief Medical Officer: _____ CRM: _____

INFORMED CONSENT FOR SURGICAL PROCEDURE

I hereby declare that:

a) I was informed by the physician identified below that assessments and tests showed alteration(s).

b) I received all necessary information on benefits, treatment alternatives, and I was informed about the risks and benefits of not taking any therapeutic action towards the nature of the diagnosed disease(s).

c) I understand that during the test(s) and/or procedure(s): _____

_____

to try to heal or improve the condition(s) mentioned above, other undiagnosed situation(s) may be revealed by the test(s) mentioned above, as well as the occurrence of unpredictable or accidental situation(s).

d) I am aware that in invasive medical procedures, as mentioned, there may be general complications such as bleeding, infection, cardiovascular and respiratory problems, among others.

e) I understand that, in order to perform the procedure(s) proposed, the use of anesthesia is necessary. Its methods, techniques and drugs used will be determined by the anesthesiologist, and I am also aware of the risks, benefits and alternatives.

f) I authorize the physician identified below, as well as his/her assistants and / or other professionals selected by him/her to intervene in the procedure.

g) I authorize any other procedure, test, treatment and / or surgery, including blood transfusion on unforeseen situations that may occur and require different care from the care initially proposed.

h) With regard to blood transfusion, I declare that I have been duly informed (a) and

- ☐ I authorize blood transfusion
- ☐ I do not authorize blood transfusion due to the following reasons: _____

I am aware that the record of my refusal regarding blood transfusion will be submitted to the medical staff that will carry out the proposed procedure for reassessment of the viability of the conduct proposed.

PATIENT/REPRESENTATIVE:

I confirm that I had the opportunity to ask questions, I received sufficient explanation, read and I understand and agree with all the information I was enlightened with and I was given the opportunity to override, question or change any item, paragraph, or words which I did not agree with.

Location _____ Date Month _____ Year 20_____ Time: _____

Legible name: _____ Signature: _____

Representative relatedness to the patient: _____ CPF (ID number): _____

WITNESS

Legible name: _____ Signature: _____

TO BE FILLED OUT BY THE PHYSICIAN

I confirm that I have explained the purpose, benefits, risks, and alternatives to the treatment described in details to the patient and /or representative or family member. I believe that the patient / representative understood what I explained.

_____

*Legible name, CRM and 'check' or stamp with CRM and 'check' *(physician's license number)*

TO BE FILLED OUT BY THE PHYSICIAN IN CASE OF BLOOD TRANSFUSION REFUSAL

On the refusal to carry out a blood transfusion, the medical team decided to:

- ☐ Decline the case, recommending: _____
- ☐ Proceed with the completion of the proposed procedure with the use of alternative methods
- ☐ others _____

_____

*Legible name, CRM and 'check' or stamp with CRM and 'check' *(physician's license number)*