Informed Consent Form

Diagnostic and therapeutic

Unit number		Ward Room Bed	National code
Family name	Name		Attending physician
Father name	Date of birth		Date of admission

This section should be completed by the Physician providing services

I am Dr. ....., the physician who treats the above-mentioned patient, regarding the diagnostic and therapeutic action that is performed in order to diagnose ……. and treat the disease..... I have given full explanation and its possible consequences, as well as its alternatives to the service recipient/ parent/ legal supporter.

Consequences of non-acceptance of diagnostic and therapeutic measures:

……

Advantages of using the recommended diagnosis or treatment:

……

The most important side effects or possible consequences of using the recommended diagnostic or therapeutic method:

……

Methods or alternative diagnostic methods with a variety of potential benefits or complications:

……

Seal and signature of the physician providing services:	Date and time of obtaining consent:

This section should be completed by the patient / legal supporter of the patient

I am …….. (patient/parent/legal representative of the patient), child of ……..holding national code number …… and birth certificate number …… issued in …… on …… (fill your date of birth), I have received the necessary knowledge of the disease, the therapeutic efficacy, and the consequences of each, as well as its alternatives by the therapist / doctor …….. and I am fully aware that the diagnostic and treatment measures in this educational and medical center are performed by the medical team under the supervision of the relevant specialists. Hereby, I express my satisfaction for the mentioned action and other necessary diagnostic and therapeutic measures that are performed at the decision of doctors and medical staff and in compliance with technical and scientific criteria, and the diagnostic and therapeutic staff are far away from any responsibility and guarantee resulting from any possible complications. Despite the observance of scientific, technical and legal standards, it may appear that I will be acquitted and I will not have any claim, whether criminal or civil.

Seal and signature of the patient/ legal representative	date and time:

This section should be completed by the witness

Name and family name ……. Father's name…… born on …… national ID card/ birth certificate……..relationship with the patient…… phone number…….

Seal and signature of witness:	date and time of :

If you are not satisfied with the proposed diagnostic-therapeutic measures, complete the following section	
In this way, while canceling the acceptance of the service, I declare my dissatisfaction with the above-mentioned diagnostic-therapeutic measures, and I would like to express my gratitude to the diagnostic and treatment staff for any harm and risks arising from not receiving the proposed treatment measures. I will have no claim of non-criminal or civil non-compliance.	
Fingerprint and signature of the patient/ legal representative:	date and time:
This section should be completed by the witness	
Name and family name …….Father's name……born on …… national ID card/ birth certificate……..relationship with the patient…… phone number…….	
Seal and signature witness:	date and time:
This section should be completed by the hospital's forensic service upon request.	
1. The recipient of the service, the parent / legal representative of the recipient of the service, was interviewed, the clinical file was studied, and the opinions of the specialized medical staff were included in the consultation form to inform. 2. The identity documents of the service recipient / the parent / legal representative of the service recipient, Ms. / Mr. ……., are in accordance with the information entered in the patient's file. 3. Service Recipient / the parent / Legal Representative of the Recipient of the Service, Mr. / Ms. ……, has the legal competence and competency to grant consent and medical innocence and the capacity to decide on the described medical affairs. 4. The patient, in the presence of a hospital forensic specialist, named Mr. / Mrs. ……..assigned as his successor and attorney for any decision in his medical diagnostic affairs if certain clinical conditions that cannot make decisions in his treatment occurred. 5. The patient / parent/ legal representative of the patient has received and understood the necessary information and awareness about the type of disease, the complications and risks of the disease and the non-acceptance of treatment, possible treatment methods, suggested treatment and its benefits, especially the side effects and risks of treatment. 6. In case of non-acceptance of the proposed treatment by the patient and the request to leave the hospital / medical center with personal consent, the specialized theory of forensic medicine should be included in the consultation form.	
Seal and signature of forensic specialist date and time	Seal and signature of the service receiver/ parent/ legal representative: date and time