Ardabil University of Medical Sciences

Valiasr Hospital of Meshginshahr

Informed consent form

For diagnostic, therapeutic, or surgical actions

Unit number:	Ward:	National code:
Name:	Bed:	Treating physician:
Surname:	Room:	Date of admission:
Father's name:	Education level:	
Date of birth:		

The treating physician completes this part.

As the treating physician of the above-mentioned patient, I, Dr. ……, have provided enough information about the diagnostic/ therapeutic/ surgical action of …… for the detection or the treatment of …… disease and its advantages, disadvantages, possible side effects, and also its alternative methods to Ms./ Mr. ……..…… the receiver of the service☐ guardian/legal representative of the receiver of the service☐ which include the following.

The advantages of the recommended diagnostic/ therapeutic/ surgical action:

Alternative methods for this diagnostic/ therapeutic/ surgical action and their possible advantages and side effects:

Consequences of not following the recommended diagnostic/ therapeutic/ surgical action

Seal and signature of the treating physician: Date and time of acquiring consent:

Patients/ guardian or legal representative of the patient completes this part

I, ……., the patient☐ guardian/ legal representative of the patient☐ with the national code of …… and date of birth of ……. have read this form (or heard its content) carefully and understood the explanations provided on the advantages, possible side effects, alternative methods, and also consequences of not following this diagnostic/ therapeutic/ surgical action. In the presence of Dr. …….. and with full freedom, consciousness, and understanding, I hereby express my agreement with the mentioned action and clear obligation from the diagnostic and therapeutic personnel, either legal or natural, as regards responsibility in case any of the mentioned side effects arise despite the observation of all scientific and technical guidelines and will not sue them legally

Signature and fingerprint of the patient/ guardian/ legal representative of the patient:

Date and time of giving consent:

In case of disagreement with the recommended diagnostic/ therapeutic/ surgical action or leaving the hospital on personal demand, this part must be completed

I hereby was duly informed of the need for the recommended diagnostic/ therapeutic/ surgical action

by the treating personnel. However, I announce my disagreement with conducting the action and clear the obligation from the diagnostic and treating personnel, either legal or natural, and accept the responsibility of not receiving the recommended diagnostic/ therapeutic/ surgical action and its consequences

Signature and fingerprint of the patient/ guardian/ legal representative of the patient:

Date and time:

Seal and signature of the treating physician:

Date and time:

Seal and signature of the supervisor:

Date and time

This part must be completed by the witnesses

First witness:

Name and surname:

Father's name:

ID number:

National code:

Relation to the patient:

Signature and fingerprint of the first witness:

Date and time:

Second witness:

Name and surname:

Father's name:

ID number:

National code:

Relation to the patient:

Signature and fingerprint of the second witness:

Date and time:

See the back of the paper