
	FORMULÁRIO / BLOCO CIRÚRGICO				
	Vigência 05/02/2028	Revisão 03	Código: HSCA.BLC.FOR.018	Página 1 de 2	
SURGICAL CONSENT FORM					

NOME: _____
 NOME SOCIAL: _____
 RESPONSÁVEL: _____
 DATA NASC. ____/____/____
 CONVÊNIO: _____ ATENDIMENTO: _____

I hereby declare that I was informed by the physician about:

Indication: _____



Risks: _____

Benefits: _____

I declare that I have been previously and adequately informed about the procedure, examination, treatment, and/or surgery to which I will be submitted, regarding indications, benefits, risks, potential complications, and/or adverse and side effects, as well as treatment alternatives. On that occasion, I had the opportunity to clarify all existing points and doubts, which were satisfactorily answered. I understand that medicine is not an exact science and that there is no absolute guarantee regarding the results to be obtained. I also authorize the performance of any other procedures, examinations, treatments, and/or surgeries, including blood transfusion and blood products, in unforeseen situations that may arise and require care different from that initially proposed.

I am aware that to carry out the proposed procedure(s), the use of anesthesia will be necessary, whose methods, techniques, and drugs will be indicated and explained in due course by the anesthesiologist. I am aware that, for my safety, I cannot undergo the proposed procedure(s) while wearing adornments (earrings, piercings, necklaces, bracelets, watches, rings and wedding bands), makeup, false eyelashes, hair extensions, painted nails, glasses, or contact lenses.

I declare that I have been informed and my consent was obtained before the invasive procedure was performed.

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To be filled by the patient

I confirm that I have received explanations, read the term, understood it, and agreed with the items mentioned above, and that I was given the opportunity to cancel any blank spaces, paragraphs, or words with which I did not agree.

☐ Patient ☐ Representative

Legible name: _____

Passaport number: _____

Representative relatedness to de paciente: _____

Signature: _____

Date of procedure: ____/____/____ Time: ____:____

To be filled out by the physician

☐ I declare that I have explained to the patient and/or their guardian the entire procedure, examination, treatment, and/or surgery to which the above-mentioned patient will be subjected, including indications, benefits, risks, and alternatives, and have answered any questions they may have. To the best of my understanding, the patient and/or his/her representative is capable of understanding the information provided.

☐ It was not possible to obtain consent because it was an emergency

Legible Name: _____ CRM: _____

Signature: _____