

FILL IN WHEN THERE IS NO LABEL	
Name _____	Date ____/____/____
Date of Birth ____/____/____ Age _____	Hour ____:____
Agreement _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Registration _____ Bed _____	

I authorize the performance of the invasive and/or surgical procedure(s) (do not use acronyms or abbreviations):

Indicated by the doctor mentioned below and his team, doctors accredited at the institution.

I declare that I have been previously and adequately informed about the procedure(s), examination(s), treatment and/or surgery(ies) to which I will be subjected, regarding indications, benefits, risks, potential complications and/or adverse and side effects, as well as treatment alternatives, following a medical assessment of my clinical condition which was duly explained to me. At the time, I had the opportunity to clarify all existing points and doubts, which were answered satisfactorily. I understand that medicine is not an exact science and that there is no absolute guarantee of the results to be obtained. The aim of this surgery is to improve the patient's health and provide relief from the symptoms associated with the specific condition being treated. The benefits of this surgical and invasive procedure(s) include, but are not limited to:

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|---|---|
| <input type="checkbox"/> Improvement in function or recovery of compromised function.
<input type="checkbox"/> Prevention of disease progression.
<input type="checkbox"/> Possibility of a better response to subsequent treatments
<input type="checkbox"/> Other. Describe: _____ | <input type="checkbox"/> Relief of pain or discomfort.
<input type="checkbox"/> Improved quality of life and general well-being.
<input type="checkbox"/> Improving physical appearance (cosmetic surgery). |
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I also authorize the performance of any other procedures, examinations, treatment and/or surgery, including transfusion of blood and blood products, in unforeseen situations that may occur and require care different from that initially proposed. I am aware that in order to carry out the proposed procedure(s), it will be necessary to use anesthesia, the methods, techniques and drugs of which will be indicated and explained in due course by the anesthesiologist.

I am aware of the risks and complications that may occur during and after the proposed procedure(s) and all my doubts have been clarified. Some risks are common to invasive procedures and surgeries, such as: pain, nausea and vomiting, bleeding, changes in blood pressure, arrhythmias, need for reoperation, difficulty walking, changes in sensitivity, difficulty healing, thrombosis and, regardless of the complexity of the procedure, unpredictable events can occur and there is a risk of death. Other risks of my procedure, if applicable, are described below: _____

Not applicable

I was informed that pain can occur after a procedure and that measures to control it will be available whenever necessary. I have understood the importance of informing the care team of the occurrence of pain.

I declare that I have been informed that, in the event of a sample of biological material being collected for anatomopathological examination during the invasive procedure/surgery, such material will be transported to a pathology laboratory, as indicated by the attending physician. The sample will be duly packaged and the laboratory informed by the medical team will be responsible for transporting the material to preserve it until the examination is processed.

I am aware that, for my safety, I cannot undergo the proposed procedures wearing adornment (earrings, piercings, necklaces, bracelets, watches, rings and wedding rings, false eyelashes, hairpieces, false nails, glasses, contact lenses), make-up, movable dental prostheses or contact lenses.

I declare that I have been advised on the risks, benefits, probability of success, possible results of lack of treatment and alternative surgical procedures, or not, to treat my condition. My consent was obtained before the invasive procedure was carried out.

Must be completed by the patient

I confirm that I have received explanations, read, understood and agree with the items referred to above and that I have been given the opportunity to clarify all doubts before the surgical procedure.

- Patient Responsible person or Guardian*

Full name* _____ Identity no. _____

Degree of kinship* _____ Signature* _____

Date ____/____/____ Time ____:____

Must be completed by the doctor

- I declare that I have explained to the patient and/or guardian the entire procedure, examination and/or surgery to which the above-mentioned patient is subject, regarding indications, benefits, risks and alternatives, having answered the questions formulated by them. According to my understanding, the patient and/or guardian is in a position to understand what has been informed.
- It was not possible to collect this consent, as this was an EMERGENCY situation.

Doctor's name / CRM or Stamp	Signature
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