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| National Code: | **فرم رضایت آگاهانه**  **Informed consent form** | | | | | File No: |
|  | |  |  | |  | |
| Attending Physician: | | Ward:  Room:  Bed: | Forename:  Date of Birth: | | :Surname | |
| Date of Admission: | | Father’s Name: | |
| **This part should be completed by the physician** | | | | | | |
| I the undersigned Dr........................................ Full explanations and necessary information to Ms. /Mr................................................... patient (recipient)"The patient's legal guardian "  Regarding a surgical/ diagnostic procedure................................................ I have given in the following cases  Advantages of using the recommended diagnostic or treatment method: ................................................................................................................................................................................................................................................................................................... .......  ..............................................................................................................................................................................................................................................................................................................  Major side effects or possible consequences of using the recommended diagnostic or therapeutic method: ................................................................................................................................................................................................................................................................................................ ..........  ..............................................................................................................................................................................................................................................................................................................  Alternative diagnostic or therapeutic method or methods, mentioning possible benefits or side effects: ............................................................................................................................................................................................................................................................................................ …......... | | | | | | |
| Doctor's seal and signature: Date and time of obtaining consent: | | | | | | |
| **This part should be completed by the patient/legal guardian of the patient** | | | | | | |
| I the undersigned ........................................... (patient □ / legal guardian of the patient □) son of ........................... holding national code..................................... nationality No. ...................................... issuing from .............................. date of birth ....../ ........./ ............... With full knowledge, I declare my consent for the action and other necessary diagnostic and therapeutic measures that are performed according to the discretion of the doctors and medical staff and with technical and scientific standards compliance, and I absolve the diagnostic and treatment staff from the responsibility of possible complications that may arise despite the observance of scientific, technical, and legal standards, and I will not have any criminal or legal claims. | | | | | | |
| Signature & fingerprint of the patient / legal guardian of the patient | | | | Date and time of obtaining consent: | | |
| **This part should be completed by the witness** | | | | | | |
| **First witness:**  Full name.......................................... Father’s name........................... Nationality No. / National code.......................... Relationship with the patient.............................. phone No....................................  Witness’s signature& fingerprint: Date& time: | | | | | | |
| **Second witness:**  Full name.......................................... Father’s name........................... Nationality No. / National code.......................... Relationship with the patient.............................. phone No...................................  Date& time Witness’s signature& fingerprint: | | | | | | |
| **This part should be completed by the anesthesiologist** | | | | | | |
| I the undersigned Dr............................................ the anesthesiologist gave the necessary explanations and full knowledge to Mr./Ms. ........ patient □ / patient's legal guardian □ regarding the recommended method of sedation/anesthesia ............................ that for diagnosis and treatment of................ ................................................ patient required; in addition, I have given necessary knowledge about:  Advantages of using the above method: ..............................................................................................................................................................................................................................................................................................................  ..........................................................................................................................................................................................  The main side effects or possible consequences of using the above method: …………....................................................................................................................................................................................................................................................................................  ...........................................................................................................................................................................................  The main side effects and possible consequences of using sedation and alternative anesthesia: ....................................................................................................................................................................................................................................................................................................  ........................................................................................................................................................................................... | | | | | | |
| Seal and signature of the anesthesiologist: Date and time of obtaining consent: | | | | | | |
| **This part should be completed by the patient/legal guardian of the patient** | | | | | | |
| I’m....................................... (patient □ / the legal guardian of the patient □) son of ........................... holding the national code ..................................... and nationality No. ...................................... issued from .............................. date of birth ....../ ........./ ............... With full knowledge, I declare my consent for the action and other necessary diagnostic and therapeutic measures that are performed according to the discretion of the doctors and medical staff and with technical and scientific standards compliance, and I absolve the diagnostic and treatment staff from the responsibility of possible complications that may arise despite the observance of scientific, technical, and legal standards, and I will not have any criminal or legal claims. | | | | | | |
| Signature& fingerprint of the patient and the legal guardian of the patient: | | | | Date& time of obtaining the consent: | | |
| **This part should be completed by the witness** | | | | | | |
| **First witness:**  Full name: .......................................... Father’s name: ........................... nationality No / national code .......................... relation to the patient .............................. phone No: ................................... Witness’s signature& fingerprint: Date& time: | | | | | | |
| **Second witness:**  Full name: .......................................... Father’s name: ........................... nationality No / national code.......................... relation to the patient.............................. phone No................................... Witness’s signature& fingerprint: Date& time : | | | | | | |
| **This part should be completed by the patient if he/she is not satisfied with the suggested**  **diagnostic/therapeutic/surgical procedure** | | | | | | |
| I Hereby declare that I was sufficiently informed, by the necessary explanations provided by the medical staff, about the necessity of diagnostic/therapeutic/surgical measures. ....................................... However, I declare my withdrawal and lack of satisfaction of doing it, and I shall not hold the diagnostic-therapeutic staff, responsible for any damage and risks caused by not receiving treatment measures, and I shall not have any criminal or legal claims, And I take responsibility for all the consequences of this decision. | | | | | | |
| Signature& fingerprint of the patient/ the legal guardian:  Date& time: | | | | Signature& fingerprint of the physician:  Date& time: | | |
|  | | | | | | |
| **Attention:**   * Obtaining informed consent is mandatory for all procedures that are subject to it, except for patients who are: under special treatment programs such as (chemotherapy, frequent blood transfusion, plasmapheresis, peritoneal dialysis and hemodialysis), provided that the following conditions remain constant, consent can be obtained once at the beginning of the treatment period, and this consent is valid for one year.   1- patient’s condition 2- How to treat 3- Alternative therapies 4- Probability of risk and benefit of the treatment method 5- Patient’s capacity to give consent should not change  6- The patient does not withdraw his/ her previous consent.  Consent is not required only in life threatening situations. The validity period of any informed consent regarding surgery / invasive procedure is a maximum of 30 days. | | | | | | |