OSWALDO CRUZ
HOSPITAL ALEMÃO

FOR EXCLUSIVE USE OF HOSPITAL ALEMÃO

OSWALDO CRUZ PATIENT LABEL

INFORMED CONSENT FOR ANESTHESIA OR SEDATION

INFORMED CONSENT - TECHNICAL NORM (RESOLUTION) SS-SP 169 DATED JULY 19, 1996

TO BE FILLED OUT BY THE PATIENT

1. I, _____, bearer of ID Card RG/RNE no. _____, authorize the execution of the anesthetic procedure (anesthesia or sedation): _____ by the doctor who has been identified below, or by any other doctor responsible for the anesthesia or sedation procedure, provided they have been duly accredited by Hospital Alemão Oswaldo Cruz.

2. The anesthesia or sedation process to which I shall be subject, as well as its benefits, risks, potential complications and alternatives have been clearly explained by the doctor identified below. I had the opportunity to clarify all my doubts in a satisfactory manner, and I understand that no absolute guarantees have been given regarding the results that are to be obtained.

3. I am aware that complications may occur during the procedure, and, on the strength of these unforeseen circumstances, I authorize any other procedure, examination, treatment and/or surgery which may be done, and which may require changes in regards to the procedure proposed initially.

4. I confirm having received the explanations, which I read, agreeing with everything that has been explained to me, and that I have had the opportunity to void, to question or to change any spaces left blank, paragraphs or words with which I do not agree.

- ◯ Patient
- ◯ Person responsible for the Patient

Name: _____