OSWALDO CRUZ
HOSPITAL ALEMÃO

EXCLUSIVE USE OF HOSPITAL ALEMÃO OSWALDO CRUZ
PATIENT IDENTIFICATION LABEL

InFORmED COnsEnT FOR pROCEDUREs anD sURgERIEs

Informed Consent - Technical Norm (Resolution) SS-SP SS-169 dated 06/19/96

I authorize the performance of the following procedure(s) and/or surgery(ies):
____
on patient: ____
In case these procedures involve any lateral procedures, specify: ( ) Right ( ) Left ( ) Bilateral, as indicated by the doctor/ surgeon-dentist, Dr ___________________________ I have been informed of the results of evaluations and examinations which have revealed the following alterations and/or diagnosis: ____
____

1. I have received clear explanations as to the alternatives to the treatment, benefits and potential complications.
2. I authorize any other procedure, examination or treatment, including blood transfusions and/or surgery, which may become necessary as arising from unforeseen circumstances, and which may require different medical care from that proposed initially.
3. I authorize the disclosure of any medical information contained in my medical file for the exclusive scientific purposes of the institution, provided that my identity is kept secret.
4. I authorize any organ and tissue surgically removed during the procedure performed to be forwarded for complementary examinations, provided said examinations are necessary to clarify the diagnostic and treatment, as well as for scientific and educational purposes.
5. I authorize the filming/taking of pictures and, if necessary, the publication of said images for scientific purposes. I am also aware that such procedures are to be performed by professionals referred by my doctor/surgeon-dentist, without any financial encumbrances, either present or future, provided my identify is kept secret.
6. In spite of having understood the explanations that have been presented, and having been clarified on my doubts and being fully satisfied with the information received, I reserve myself the right to revoke this consent before the procedure(s), object(s) of this document, is/are performed.
7. I am aware that I can request clarifications of any doubts of mine which may arise at any stage of the treatment.
8. I am aware that at the time I am discharged I shall be accompanied by an adult.
9. I represent that I have received the explanations, which I understood, and I had the opportunity to clarify my doubts. I agree with what has been said above, and that I was given the right to void at this time any spaces left blank, any paragraphs or words with which I did not agree.

☐ Patient ☐ Person responsible for the Patient

Name (legible): ____
Signature: ____
Relationship to patient: ____
ID Card RG no.: ____

Sao Paulo ____ / ____ / _______ Time: ____ : ____

TO BE FILLED OUT BY THE DOCTOR
I have explained in a clear and objective manner the entire procedure, test, treatment end/or surgery to which the above mentioned patient is to be subject to, to the patient themselves and/or the person responsible for them, as well as the benefits, risks and alternatives, and that I have answered the questions made by them. From my point of view, the patient (or the person responsible for them) is able to understand what they have been told.

Name of doctor:____ CRM:__________________

Signature: ____