



Unit number		Ward	National code
Family name	Name	Room	Attending physician
Father name	Date of birth	Bed	Date of admission

**This section should be completed by the Physician providing services**

I am Dr. ...., the physician who treats the above-mentioned patient, regarding the diagnostic and therapeutic action that is performed in order to diagnose ..... and treat the disease.... I have given full explanation and its possible consequences, as well as its alternatives to the service recipient/ parent/ legal supporter.

Consequences of non-acceptance of diagnostic and therapeutic measures:  
 .....

Advantages of using the recommended diagnosis or treatment:  
 .....  
 The most important side effects or possible consequences of using the recommended diagnostic or therapeutic method:  
 .....

Methods or alternative diagnostic methods with a variety of potential benefits or complications:  
 .....

Seal and signature of the physician providing services:	Date and time of obtaining consent:
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**This section should be completed by the patient / legal supporter of the patient**

I am ..... (patient/parent/legal representative of the patient), child of .....holding national code number ..... and birth certificate number ..... issued in ..... on ..... (fill your date of birth), I have received the necessary knowledge of the disease, the therapeutic efficacy, and the consequences of each, as well as its alternatives by the therapist / doctor ..... and I am fully aware that the diagnostic and treatment measures in this educational and medical center are performed by the medical team under the supervision of the relevant specialists. Hereby, I express my satisfaction for the mentioned action and other necessary diagnostic and therapeutic measures that are performed at the decision of doctors and medical staff and in compliance with technical and scientific criteria, and the diagnostic and therapeutic staff are far away from any responsibility and guarantee resulting from any possible complications. Despite the observance of scientific, technical and legal standards, it may appear that I will be acquitted and I will not have any claim, whether criminal or civil.

Seal and signature of the patient/ legal representative	date and time:
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**This section should be completed by the witness**

Name and family name ..... Father's name..... born on ..... national ID card/ birth certificate.....relationship with the patient..... phone number.....

Seal and signature of witness:	date and time of :
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