Clínica Especializada de Azuero
CUIDANDO TU SALUD

Pegar Label Aquí

## CONSENTIMIENTO INFORMADO PARA PROCEDIMIENTO MEDICO Y QUIRURGICO

**Complete Name: JUAN GONZALEZ**
**Date of Birth: 01/09/1971**

**My physician(s) has (have) informed me the procedure(s) he/she plans on doing is (are) the following; surgery or treatment to be performed:**

_____

_____

_____

CLINICA ESPECIALIZADA DE AZUERO S.A and all its affiliates consider you have the right to be informed and make decisions regarding the treatments and medical and/or surgical procedures to be performed. You must be involved in the decision about this process. Your physician(s) must provide you with the information about the medical/surgical treatment proposed based on your condition.

The following information contains a standard text of informed consent for medical and surgical procedures, used for minor procedures, as well as for the more complicated and serious ones. It hasn't been created to alarm or scare you; it's an effort to keep you FAIRLY INFORMED and explain that ALL procedures involve risks.

**If you're not clear about something, please ASK your physician(s).**

**If you have unanswered questions or doubts, DON'T SIGN THIS DOCUMENT.**

**INFORMED CONSENT**

**1.** I acknowledge that during the course of my surgical procedure, post-op care, medical treatment, anesthesia, pain management or other procedure, there are unexpected conditions, as well as related risks and complications that may require different or additional procedures than the ones mentioned in the current document . For this reason, I authorize my physician(s) and his/her assistants to perform that surgical procedure or any other procedure necessary as part of their good practice and professional judgment. The authorization I'm giving extends to the treatment of all conditions that may require immediate treatment and/or related complications that may arise as potential inconveniences and/or risks during or after the procedure or surgery.

I have been informed there are important risks such as allergic reactions, clots in the veins and lungs, blood loss, infections, cardiac arrest, that can lead to death, partial or permanent disability that must be taken care of.

**2.** I acknowledge that in the cases where incisions and/or sutures are required, infections, pain in the wound, hernia formation (weakness or bulging) may occur and that these complications can require treatments or future procedures.

**3.** **I acknowledge the list of risks and complications mentioned in this document may not include all the possible and known risks of the surgery or procedure to be performed, but it states the most common and severe complications.**

**4.** **I acknowledge my physician(s) has (have) mentioned the reasonable and expected benefits, but hasn't given me any guarantee or safety in the result that may be achieved from the surgery, procedure or cure for my condition.**

**5.** I give my consent for the use of blood transfusions and blood products that may be necessary under my physician(s) criteria. I'm aware of the risks included related with blood transfusions and have the knowledge that CLINICA ESPECIALIZADA DE AZUERO S.A practices all the laboratory tests necessary and currently available to avoid any transmissible disease such as Hepatitis and HIV, but I have been informed as well of the risk of contracting these diseases due to the possibility of them being in the incubation period or window at the moment the tests are performed in the donar, therefore not being detectable by any lab test.

**6.** I authorize my physician(s) to dispose the tissues or part of them that may be surgicaliy removed for histopathological studies, for example, according to the usual procedures .

**7.** **I UNDERSTAND ANY ASPECT OF THIS DOCUMENT I MAY NOT UNDERSTAND MUST BE EXPLAINED TO ME WITH FURTHER DETAILS BY MY PHYSICIAN(S) OR ASSOCIATES.**

**8.** **I certify my physician(s) has (have) given me the opportunity to make questions and has (have) informed me of the character and nature of the medical/surgical procedures proposed, benefits obtained from them, including the consequences of not receiving a treatment. I have been informed of the possible complications, known risks and alternative treatments.**

**9.** The following are exceptions regarding the treatment(s) and/or test(s) and/or surgical intervention(s) and/or procedure(s) and/or medication supplies and/or transfusions and/or anesthesia that may be considered at one point (Describe or deny patient's allergies):

**10.** I'm aware the treating physician(s) is (are) not an employee(s) at CLINICA ESPECIALIZADA DE AZUERO S.A; therefore, I exonerate CLINICA ESPECIALIZADA DE AZUERO S.A of any responsibility or negligence from the physician(s), which includes, but is not limited to not acting against CLINICA ESPECIALIZADA DE AZUERO S.A due to those circumstances.

**11.** **I CERTIFY I HAVE ENOUGH INFORMATION TO GIVE MY CONSENT AND THAT MY PHYSICIAN(S) HAS (HAVE) ASKED ME IF I WISH FOR A MORE DETAILED INFORMATION, BUT I'M SATISFIED WITH THE EXPLANATIONS GIVEN TO ME AND DON'T REQUIRE MORE INFORMATION.**



**Patient's signature**

**Signature of legal guardian or representative**

**Witness (only of signature)**

**Physician's signature**

**Date: 11/04/2024 04:19:05 PM**