GENERAL INFORMED CONSENT DOCUMENT FOR HOSPITAL TREATMENT

I,.....(first name and last name).....(date of birth)…… ……..(address)……(citizenship) give my consent for myself or assent on the behalf of my family member ……..(first name and last name) ……(date of birth) ……. (relatedness) to undergo the necessary diagnostic work up and pharmacological treatment or other medical intervention recommended by my (or my relative's) physician based on her/his best consciousness and judgement.

Diagnosis at admission: …….

I have received clear information and explanation regarding my condition and disease, the recommended diagnostic work up, planned and feasible treatment modalities, foreseeable risks and consequences, side effects, and possible adverse effects, which I fully understood. My questions were answered with clarity, and I had sufficient time without undue influence to make a free decision. I was also informed about the potential advantages and disadvantages of alternative diagnostic examinations and treatment options. I was told that my physician will continuously inform me about my condition and the evolution of it, while will also inform me about arising needs for additional examinations and treatments.

I accept that unforeseen complications may arise even when the highest standard of care and the state of art medication is applied, which may negatively influence the time frame of care and outcome. Additional notes: ……

I was told, that separate consent will be requested in case of special tests and examinations, and surgical or other invasive interventions. Additional notes: .....
.....

I am aware of my right to refuse the recommended investigations and treatments. I here relieve from the legal responsibility for the potential consequences, complications or adverse medical outcome those physicians whose recommendations I have refused, despite receiving proper information as to what risks I am taking in case of rejecting the diagnostic work up and treatment, interrupting the treatment or postponing the treatment.

I give my consent that the medical staff may give information about my health condition to my relative(s) named under the „closest relative" segment of my medical chart.

I accept the information about the general patients' rights, and the house rules at the hospital, and acknowledge my responsibility for my valuables and personal items during my hospital stay.

I accept the handling of my personal (protected) information by the hospital staff, and the placing of the identifying tape on my wrist.

I here state my consent to subject myself to diagnostic examinations, treatment interventions, tests such as blood drawing or other tissue sampling, pharmacological treatments and infusions, possible transfusion(s), and necessary examinations with medical devices and imaging modalities involving contrast injections. I give this consent free of pressure or any other improper influence after receiving thorough information.

Szombathely, 20 ..... year ..... month ..... day ..... hour …….. minute

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Signature of the physician	Signature of the patient's legal representative

STATEMENT CONCERNING THE REJECTION OF MEDICAL MANAGEMENT AND CARE

I here state that I have received thorough information regarding my (or my named relative's ……) disease, the necessity of examinations and treatments, and the risks of avoiding these interventions. Fully informed and aware of my personal responsibility, I do not consent to subject myself or my named relative to undergo the necessary examinations and care, and I relieve from responsibility for the potential adverse outcome or complications those physicians whose recommendations I have refused.

I acknowledge here that despite the recommendations of the physician, I refuse to subject myself or my relative to the diagnostic examination and treatment, do not accept the recommended planned treatment, and leave the hospital (with my relative) on my own responsibility.

Szombathely, 20 ..... year..... month ..... day ..... hour …….. minute

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Signature of the physician	Signature of the patient's legal representative
.....	……
Signature of witness	Signature of witness