Szpital św. Łukasza

St. Lukas Hospital, Bystrzańska 94b Street, Bielsko-Biala, POLAND, bank account number: 22 8131 0005 0016 3011 2000 0010
Treatment Planning +48 33 819 95 24, Patient Service +48 33 819 95 10, fax +48 33 819 95 31, www.lukasza.pl

Patient Informed Consent for providing health benefits and Patient Declaration

Please read the form and ask questions if in any doubt - our duty is to provide you with all the necessary explanations.

Patient's Name:……

Place and date of birth……

PESEL (NIP, VAT)……

Address……

History of the illness……

Legal guardian/ curator/ actual guardian of the patient……

Type of Treatment/ surgery……

I hereby declare that:

a) I have been informed and familiar with the detailed description of the proposed diagnostic method / method of treatment (surgery), its purpose and expected outcome and potential hazards which may occur during and as a result of test / diagnostic procedure / treatment, as well as the consequences of my refusal.
b) I have given thorough and true answers to the questions that the doctor asked me during the medical interview about my state of health, medication, and completed treatment
c) The information concerning my state of health, diagnosis, proposed and possible methods of diagnosis, treatment, medical surgery, anesthesia, foreseeable consequences of their application or omission, the outcome of treatment and prognosis was presented in a manner accessible to me.
d) I was informed of possible use of alternative methods of diagnosis / treatment, anesthesia, risks and complications that may occur during or because of research / treatment / surgery, as well as about the consequences of failure of me permission.
e) I was informed of the possibility of unforeseen situations, which may require modification of the state of the scope of the examination / treatment, as well as the possibility of an appeal of my previously granted consent for any action related to the diagnosis / treatment.
f) I have obtained comprehensive, clear and understandable answers to all the questions, I have been explained all activities regarding the proposed procedure / methods of diagnosis / treatment, the risks and complications that may occur during or as a result of treatment / research. During the consultation with the doctor, I was able to ask questions about the proposed medical procedure.

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g) Patients' Rights Charter was made available to me and I was informed of the possibility of unlimited access to the document.

h) I was informed and I am fully aware of the fact that at any time I can withdraw my consent to perform surgery, any study / application of the method of treatment.

i) I was informed about the effects of accession to the surgery without a completed vaccination against hepatitis and it is my informed consent to carry out the operation and waive any claim against the doctor and St. Luke's Hospital.

j) I acknowledge that any medical treatment, anesthesia, administration of blood or blood products, entails the risk of complications (including serious complications, infections, and even death), which can occur even at the highest standards in terms of knowledge, skills and medical care.

k) I have been informed of the possibility of the occurrence of need for treatment with blood in case of excessive bleeding during the surgical site or in the perioperative period and the possible risks / complications related to this. **I agree / do not agree *** to blood transfusion and / or blood products in this case.

l) **I agree / do not agree *** for possible modification of the way the proposed methods of diagnostic / treatment (surgery) to the extent necessary - in accordance with the principles of medical knowledge will be required if this situation arose as a result of the diagnostic / treatment process.

m) **I agree / do not agree *** to record my surgery on media image and audio recording and use of this provision for the purpose of medical records and scientific documentation

n) **I give permission / do not give permission *** to inform about the state of my health and the transmission of documents, medical records and objects from hospital deposit on my behalf to a person authorized, ie (name, phone and address):

……

……

……

o) **I agree / do not agree *** to transfer me to the correct hospital ward / another hospital, if required by the state of my health.

p) I'm a part of ..... OW NFZ and I am insured in ....

q) **I agree / do not agree *** to take part in the survey after my hospitalization conducted by external company on behalf of St. Luke's hospital.

I do consent to the processing of my data by National Health Found (NFZ) and St. Luke's Hospital (Szpital św. Łukasza BGL Sp. z o. o. S.K.A.) in Bielsko-Biała.

_____

Date and Signature of Patient / legal guardian / guardian / actual guardian of the Patient

_____

Date and signature of receiving the physician approval

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Additional recommendations for the Patient:

1) The results of laboratory tests provided by the patient during a hospital admission cannot date back more than 7 days, and the result ECG cannot date back more than 30 days.

2) The patient should inform the Hospital about her/his food allergies or dietary preferences (e.g Vegetarian) at the time of admission to hospital.

3) In order to arrange the anesthesia consultation, the patient can contact the registration (Patient Service Office) personally, through a third party or by phone at +48 33 815 11 13 or +48 33 819 95 10.

_____

Date and Signature of Patient / legal guardian / guardian / actual guardian of the Patient

After reading the above text, in accordance with Article 32-35 of the Act of 5 December 1996. the professions of doctor and dentist (consolidated text. Laws of 2008 No. 136, item. 857 with later. d.) and Art. 16-18 of the Act of 6 November 2008. Patients 'Rights and the Commissioner for Patients' Rights (Journal of Laws of 2009. No. 52, item. 417, as amended. amended.), in a fully conscious

I DO HEREBY AGREE/ DO NOT HEREBY AGREE*

for providing health benefits

_____

(FULL NAME OF THE TREATMENT)

_____

Date and Signature of Patient / legal guardian / guardian / actual guardian of the Patient

Listed below any procedures, which I do not agree without prior agreement:

_____
_____
_____

_____

Date and Signature of Patient / legal guardian / guardian / actual guardian of the Patient

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I hereby acknowledge receipt of the Patient Informed Consent Form signed by the Patient and at the same time I conclude that **there are/ there are no contraindications *** for the surgery.

_____

_____

_____

specify the contraindications, if applicable

_____

Date and signature of receiving the physician approval

*Delete the not necessary

**Refers to the case of the test / operation performed with the use of anesthesia.

***Statement does not apply in the cases provided for by law