**Institute of Genomic Medicine and Rare Disorders**
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## DECLARATION OF CONSENT

**Planned intervention: ……..**

Name of patient:
Social security number:
Name of legal representative/relative:
Telephone number:
Address:

Health condition, medical opinion:
……..
……..

Possible advantages and risks of completing / failing the recommended medical examinations (side effects, complications):
……..
……..

Possible advantages and risks of completing / failing the recommended interventions (side effects, complications):
……..
……..

Surgical and non-surgical possibilities:
……..

Medical examination and expectable outcome of the intervention, and the probability of the success of that:
Asking for information on complications with a probability of under 1% **YES NO**
……..
……..
Planned date and time of the medical examinations and interventions:…..……...
(The patient is aware of the possibility of variation. In case of that, he or she gets informed.)

Expectable fee of the care:……..

Questions of the patient/legal representative and answers to them:
……
……
…….

I have been informed about the risks and possible frequent complications and expectable consequences of the recommended intervention, I have received personalized answers to my verbal/written questions, and I had time enough for making a defined decision about the way of the treatment.

I allow to complete necessary intervention other than the planned one occurring during the operation, and to expand the operation in case the medical specialist considers that necessary or an urgent necessity requires that.

I accept that unpredictable complication can happen also in case of a professional treatment, which has negative effect on the expectable results and recovery time.

I accept that expect for the life support and rescue operation defined by the physician, I have the right to reject any of the recommended care. In this case, I make a written declaration about the fact of the rejection. At the request of legal representative, in case of an incapable patient or a patient with limited incapacity, care with an expectable consequence of a serious or irrevocable damage in the patient's health condition is not allowed to reject.

**I Agree, Disagree** (please underline) with the planned intervention to be completed on me.

**I Agree, Disagree** (please underline) with preserving any cell parts, tissues, organs removed for diagnostic and health care purposes related to the medical examination ad intervention by the Semmelweis University, and by the use of them, to execute scientific and medical research.

I allow my physician and other patient care service to handle my personal health care data in order to contribute the effective patient care. My physician has informed me that Semmelweis University maintains an integrated informatics health care data handling system, so information share can happen in the interest of my own care.

Budapest, 20…. ……..

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|---|---|
| Patient's or legal representative's signature | Date and witness signature |