DOKU CLINIC

INFORMED CONSENT FORM FOR SEDATION

Doküman Kodu: HD.RB.02	Yayın Tarihi: 01.05.2024	Revizyon No: 0	Revizyon Tarihi:	Sayfa No: 1 / 1	Bilgi Sınıfı: Kişisel Özel

Patient No :

Patient Name Surname :

Date of Birth : ..... / ..... / .....

Gender : ☐ Male ☐ Female

Section :

INFORMATION

PRE-DIAGNOSIS : _____

PLANNED TREATMENT : _____

ESTIMATED DURATION : _____

Dear Patient, Dear Parent/Custodian, please read this form carefully. This form has been created to inform you about the procedure. Upon having been informed, you have the right to exercise your free will to accept or refuse the procedure or refuse the procedure.

DEFINITION OF SEDATION;

All the diagnostic and therapeutic procedures during which you shall not feel pain, move or be awake will be provided in comfort and safety for you and your child by creating a sense of calmness.

INFORMATION ABOUT SEDATION;

When being admitted into the operation area; it is recommended to take a low-dose relaxant tablet by mouth with a little water. Once you are admitted into the operation room; the values for your blood pressure, pulse, oxygen level are measured and recorded. Vascular access is opened in your vena with the help of a cannula, this venous access will be accessible throughout the operation. If the recorded value falls within the normal range, a drug with sedative and painkiller properties can be administered through your vascular access; the dosage will be determined according to your age, sex and weight. Throughout the procedure; the values for your heart rate, blood pressure and oxygen levels will be monitored at intervals. For you to not to experience any pain during the procedure, local anaesthesia at an appropriate amount will also be administered to the relevant area. With the aim to meet your need for water during the operation, a serum will be delivered through your physiological vascular access.

WHAT CAN HAPPEN WHEN SEDATION IS NOT ADMINISTERED;

You will feel pain while the necessary procedures for diagnosis and/or treatment are being performed. As the patient feels pain, complete physical inactivity is not attained. Therefore, interventions for diagnosis and/or treatment will be insufficient.

SIDE EFFECTS;

Nausea, vomiting, respiratory standstill, decrease or increase in pulse rate and blood pressure may occur. Very rarely, neck pain, allergy, nerve damage, need for intubation, embolism, malignant hyperthermia, and death may occur.

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PARTICULARS TO BE STATED TO THE PHYSICIAN BEFORE A SEDATION ADMINISTRATION;

You should provide adequate information about whether such procedure was performed before, medications used before by the patient, and whether the patient has any bleeding disorders or allergies.

THE PATIENT SHALL PAY ATTENTION TO THESE PARTICULARS AFTER THE PROCEDURE;

You will be kept in observation until you are completely awake and the functions of your organs are normal before you are allowed to go back home. You will be asked to refrain from driving for 24 hours and performing dangerous jobs.

The confirmation statement of the patient, parent or custodian:

- My doctor provided me with the necessary information about my health status.
- I was informed in detail about the nature of the planned attempt/intervention, its necessity, the course of the intervention and its risks, the consequences that may occur in case I do not accept the treatment, the success rate of the treatment and its side effects.
- I understood the particulars that I should pay attention to before and after the treatment/intervention.
- It was explained to me that all documents and samples related to me, which shall be taken during diagnosis/treatment/intervention could be used for educational purposes.
- My doctor answered all my questions in a way I could understand.
- I was informed about the people who will perform my treatment/intervention.
- I am well and in full possession of my faculties and I consider myself competent to make a decision.
- I know that I don't have to give consent for the treatment/intervention if I don't want it and/or I can stop the process at any stage I want.
- I have read and understood the explanations regarding the purpose, technique, benefits, alternative methods, expected effects, possible risks and complications of the sedation application to be administered. I declare that I have been informed about the matters above and that sufficient time has been given to me to ask my questions and make my decision.

*** Please write in your handwriting and in your language: "I have read/translated, I understand, I approve".**

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Patient

Name Surname: Signature:

Date:

Hour:

Date of Birth:

Legal Representative of the Patient

Name Surname: Signature:

Date:

Hour:

Degree of Affinity:

Reason for obtaining consent from the patient's legal representative

- ☐ Patient is unconscious
- ☐ Patient cannot make a decision
- ☐ Patient is below the age of 18
- ☐ Emergency

Witness

Name Surname: Signature:

Date: Hour:

Informing Physician

Name Surname: Signature:

Date: Hour:

Tercüman* (ihtiyaç halinde)

Name Surname: Signature:

Date: Hour:

** I translated the information disclosed to the patient by the physician. I am of the opinion that the information I translated to the patient were understood by the patient, and thus, the patient consented.*