

 	Regione Siciliana Azienda Ospedaliero-Universitaria Policlinico "G. Rodolico - San Marco" Catania	PRESIDIO OSPEDALIERO / HOSPITAL FACILITY: U.O. / CLINICAL UNIT: Nome Responsabile / HEAD OF UNIT NAME:
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INFORMED CONSENT FORM

PATIENT IDENTIFICATION DATA:

Surname _____ first name _____
 Born in _____ (province/county of _____) on ____/____/____

IDENTIFICATION DATA OF ANY OTHER TITULAR SUBJECTS:

☐ PARENTS (if patient is a minor)	☐ LEGAL GUARDIAN ☐ SUPPORT ADMINISTRATOR ☐ DESIGNATED TRUSTEE
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SUBJECT 1:

Surname _____ first name _____
 Born in _____ (province/county of _____) on ____/____/____

SUBJECT 2:

Surname _____ first name _____
 Born in _____ (province/county of _____) on ____/____/____

SUMMARY OF THE PATIENT'S CLINICAL SITUATION AND POSSIBLE PROGRESSION OF THE ILLNESS

Delete if not relevant

PROPOSED HEALTHCARE ACT:

DECLARATION OF RECEIPT OF INFORMATION

I declare that on ____/____/____ I was informed by Dr. _____ regarding the proposed healthcare act and I was provided with the following informative material:

☐ Brochures ☐ Fact sheets ☐ Other _____

and that I have received comprehensible and thorough information on the purpose, potential benefits, possible complications alternatives concerning the procedure offered to me for

((please specify the pathology) Delete if not relevant

and on the possibility that the treating healthcare professionals may alter what has been offered to me if required by my condition during the course of the procedure.

Other information provided or requested by the patient:

CONSENT

I hereby freely, willingly and in full awareness

☐ **accept** ☐ **accept**

the *healthcare act* offered to me

In addition, I declare that I am aware of the option to withdraw my consent.

Comments: _____

Date ____ / ____ / ____

Full name of doctor obtaining consent: _____

Signature of patient / legal representative

Signature of doctor obtaining consent

To be completed in the event of withdrawal of consent previously given

WITHDRAWAL OF CONSENT

I hereby freely, willingly and in full awareness withdraw my consent

Date ____ / ____ / ____

Signature of patient / legal representative

Signature of doctor obtaining consent

To be completed for underage patients in the event of absence of one parent

Declaration of reason for absence of one parent

I, the undersigned

Surname _____ first name _____ born in _____

(province/county of _____), on ____ / ____ / ____ resident of (town/city) _____

(province/county) _____) street _____ N. _____

HEREBY DECLARE

1. That I am a parent of the patient:: surname _____ name _____
born in _____ (province/county of _____)

2. That I have been informed of the regulations under the Italian Civil Code governing the provision of consent for underage children.

3. That, for the purposes of application of Art. 317 of the Italian Civil Code, the other parent is unable to sign in consent due to absence for the following reason:

☐ geographical distance ☐ impediment ☐ other _____

4. That, for the purposes of application of Italian Law 8/2/06 no. 54 Art. 1, as regards decisions on matters of ordinary administration, the judge has ruled:

☐ that the undersigned has separate parental authority

☐ other _____

Location and date _____ Declarant _____

Signed by the subject in the presence of: _____

(signature of doctor)