Consent form for non-invasive diagnostic procedures/treatment performed at Heim Pál National Pediatric Institute

Patient's Name: .....

TAJ (Medical Insurance) Number:.....

TAJ (Medical Insurance) number alternatives: DOB:.....

Mother's Maiden Name:.....

Patient's Legal Guardian's Name:.....

Guardian's Registered Address:.....

Patient's Medical Condition(s): .....

Description of intended diagnostic procedures:

-Drug therapy

-Blood collection

-Venipuncture:

-Non-invasive diagnostic imaging (X-ray, ultrasound)

-Other:

Potential complications of diagnostic tests, treatments

-Medication allergy, unexpected side effects

-Complications relating to the present condition of the patient

-Venipuncture: repeated punctures, tissue infiltration, haematoma, circulation problems

Other:

Esteemed Parent/Guardian!

In the event that you do not agree with any of the below listed items, or feel that you have not received adequate information about it, please mark the item clearly by drawing a line through it and signing under the line.

I consent that I have been adequately informed about the purpose and nature of the diagnostic procedure and the related potential risks and/or complications that can be expected despite the precautions taken. Additionally I agree that I have been informed about any possible alternatives to the planned procedure and its advantages and/or disadvantages. I understand that the expected outcome cannot be guaranteed.

I consent that I have been adequately informed of the intended procedure, including updated research and science pertaining to the procedure(s) and the most common potential side effects and/or complications.

I empower the medical staff, including physicians, assistants, nurses and others involved in the patient's treatment or surgery, to perform the listed procedure, including any unforeseen interventions necessary to maintain the patient's health and well-being that may arise during the performance of the intended procedure that are time-critical to prevent a degradation of the patient's condition.

I consent to all necessary pharmacological or intravenous therapy.

I consent to allow students in various health science disciplines, only up to their level of training and experience, to treat my child with adequate oversight by fully licensed specialists.

I consent to photographic or video images being taken during the procedure with the guarantee that no image will contain any uniquely identifiable area of my child. In the event that the object of the photograph or video requires that an identifiable part of the patient is recorded, the further use of such photograph or video will require an additional permission from the patient, parent or guardian.

I consent to the use of any tissue, fluid, or organ removed from the patient for scientific purposes after any needed biopsy has been taken.

I agree that all my questions or concerns regarding any portion of the listed procedure have been addressed adequately by the physician(s).

I agree that I have shared all pertinent information with the physician regarding the patient's medical condition, prior medical history, medication allergy or sensitivity, or previous medical interventions.

I agree that on this day I am the legal parent and/or guardian of the aforementioned minor and that my legal guardianship has not been suspended/limited/or revoked.

Budapest, 20……,……..

…… ……..

Patient's Parent or Legal Guardian Physician

…….

Patient (if 16 years old or older)

Witness 1 Witness 2

…….. ……

NONCONSENT FORM

After careful consideration of the consent form, and consultation with the physician(s) I opt not to allow the recommended diagnostics/procedure(s)/ surgery to be performed. I understand that I cannot hold the hospital, physician or medical staff liable for any consequences resulting from denial of the recommended procedure(s)/treatment.

I understand that if my child is a terminally ill patient, has a condition that is not treatable due to limits in treatment and medicine, or is incapacitated in any form, and I decide to withhold any potentially life-saving treatment(s) or procedure(s) or contradicts the normal progression of the disease, the treating physician or medical institution can initiate a court ordered consent for treatment or diagnosis which the physician and medical institution will be required by law to conform to. If there is an immediate and impending threat to life, a court order is not necessary for medical intervention to be performed.

I understand that the treating physician or medical facility can turn to law enforcement to assist in the above mentioned requirements of the law (Eütv.20-21.§)

Budapest, 20…. …….

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Patient's Parent or Legal Guardian Physician

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Patient (if 16 years old or older)

Witness 1 Witness 2