CENTRE HOSPITALIER
Dr Jean Eric TECHER
Calais

CONSENT

SERVICE :

Ms or Mr ....
Born in ....

During the consultation of .... or during my hospitalization in the service of .... to benefit from an intervention surgical procedure, invasive exploration or treatment and more specifically:
....

I was given precise information on the reasons for these acts, I was informed of the other possibilities of treatments, when they exist, with their advantages and disadvantages.

It was clearly explained to me the nature of the acts that will be practiced and their possible counter-acts, indications, what I must do to prepare myself, possible discomfort that may occur, and the most common risks and complications, including infectious risks.

I was also warned that during the act, a discovery or an unforeseen event could occur. I accept technical changes that may be necessary during the intervention or after the act.

I had the opportunity to ask questions and the Doctor ....
has responded fully and satisfactorily. I understood the answers that were provided to me. I freely give my consent to perform the act provided for in the above conditions and declare that I have the possibility to withdraw this consent at any time prior to the intervention.

My consent also concerns the necessary serological screenings.

I expressly agree to go to the necessary consultations for the intervention (pre-anesthetic consultation, biological samples, explorations ... etc ...).

ADVANCE DIRECTIVES

In accordance with the law you are entitled to express, if you wish freely in writing to your doctor or to your person of trust, your will concerning the therapeutic decisions (resuscitation etc ...) or the conditions of your end of life. A document to help draft advance directives can be distributed to you at your request.
I note the existence of such advance directives and send a copy of this document for archiving in my file: ☐ yes ☐ no

Date : Sign :

NB: This document signed by you must be reported to me on the 1st day of your hospitalization.

TO BE COMPLETED BY THE PATIENT

IDENTITY OF THE PATIENT

Name : .... First Name : .... Birthdate : ....
Adress : ....

PERSON TO CONTACT

Name : .... First Name : ....
Bond : ....
Adress : ....
Phone : .... Cell Phone : ....

PERSON OF TRUST (loi 2002-303 du 04 mars 2002 relative aux droits des malades et à la qualité du système de santé)

☐ I wish to appoint a person of trust for the duration of my hospitalization.
I fill in the form for the appointment of the person of trust distributed by the Hospital Center.

☐ I do not wish to appoint a person of trust for the duration of my hospitalization.

REFUSAL OF COMMUNICATION OF THE MEDICAL DOSSIER

In accordance with the law 2002-303 of March 04, 2002 and the decree 2002-637 of April 29, 2002 relating to the access to the personal information held by the professionals and the health establishments and to the decree of March 05, 2004 relating to the recommendations good practices relating to access to information on the health of a person and the accompaniment of this access:

☐ I refuse that my medical file be communicated to my beneficiaries.

CONFIDENTIALITY

The Hospital Center is bound to respect the confidentiality of the medical and personal data acquired during your stay in the establishment. For more confidentiality, a hospitalization under cover of anonymity can be implemented at your request.

☐ I wish that my identity in the establishment remains **strictly confidential** (anonymity).

GENERAL PRATICIAN :

Name : ....
Adress : ....

SPECIALIST PRATICIAN :

Name : ....
Adress : ....

SIGN :

DATE :