

Unità Operativa _____

DICHIARAZIONE DI CONSENSO INFORMATO

Cognome e Nome

Nato/a il a

Atto sanitario da effettuare

The undersigned

Born on ____/____/____ in

Residing at

In his/her capacity as: ☐ person concerned ☐ parent ☐ guardian of the person* ☐ Support Administrator*

DECLARES:

- that he/she has received adequate information and has understood this ☐ YES ☐ NO
- that he/she has received answers to any questions he/she has asked ☐ YES ☐ NO
- that he/she is aware of any alternative choices ☐ YES ☐ NO
- that he/she is aware of the consequences resulting from refusal ☐ YES ☐ NO
- that he/she is aware of the possibility of revoking consent ☐ YES ☐ NO
- that he/she is aware that this consent includes all the necessary treatment cycles, whether on-going or not and related and consequent treatment ☐ YES ☐ NO
- that he/she had the necessary time to decide ☐ YES ☐ NO

he/she ACCEPTS the PROPOSED HEALTH DEED ☐ YES ☐ NO

Date Signature

Should one parent be absent: The undersigned, furthermore, aware of the responsibilities and criminal punishment stated in art. 76 of DPR 445/2000 for counterfeit certificates and false statements, under his/her own responsibility,

- ☐ the same states to have correctly informed the other parent and to have received the consent from the same
- ☐ the same states to have sole parental authority

Parent's Signature

- ☐ Should the user be found to be of unsound mind:

***Signature of the Legal Guardian /Representative/Support Administrator**

(attach self-certification from Legal Guardian/ Representative /Support Administrator)

Dichiaro di aver raccolto l'anamnesi, di aver fornito informazioni specifiche sull'atto sanitario e di aver precedentemente fornito la relativa scheda informativa in merito a indicazioni, controindicazioni, eventuali effetti secondari/ complicanze, alternative, conseguenze, secondo quanto previsto dalla procedura aziendale del consenso informato. Dichiaro di aver risposto esaurientemente a tutte le domande rivolte e nel caso di utente straniero, che non comprende la lingua italiana, di aver provveduto a fornire informazioni nella lingua d'origine e/o conosciuta o con intervento di un mediatore/interprete.

Firma e timbro di chi acquisisce il consenso

Firma e timbro di chi ha effettuato l'atto sanitario

The undersigned declares that he/she revokes the consent given previously on (date) signature

Data Firma e timbro di chi ha acquisito la revoca