Informed Consent Form Medical

### **Part 1: Patient Information**

**Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient's ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Part 2: Medical Procedure**

**Description of the Procedure/Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Expected Benefits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Possible Risks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Part 3: Physician's Statement**

**I, \_\_\_\_\_\_\_\_\_\_\_\_ (Physician's Name), have explained the nature, purpose, benefits, and potential risks of the medical treatment or procedure. I have answered all questions fully and accurately.**

### **Part 4: Consent Declaration**

**I consent to undergo the treatment or procedure as described and accept the potential risks involved.**

### **Part 5: Patient or Legal Guardian Signature**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**