HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

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| **Department:** | Quality Management and Patient Safety | | |
| **Document:** | Multidisciplinary Policy and Procedure | | |
| **Title:** | Consent Policy | | |
| **Applies To:** | All Medical and Nursing Staff | | |
| **Preparation Date:** | November 10, 2024 | **Index No:** | QM&PS-MPP-002 |
| **Approval Date:** | November 24, 2024 | **Version :** | 2 |
| **Effective Date:** | December 24, 2024 | **Replacement No.:** | QM&PS-MPP-002 (N) |
| **Review Date:** | December 24 2027 | **No. of Pages:** | 12 |

## 1. PURPOSE:

1.1 To provide guidelines for obtaining the general consent.
1.2 To provide guidelines for obtaining the patient's informed consent for medical and surgical high risk procedures.
1.3 To involve the patients in their care decisions.
1.4 To release the medical staff and the hospital from all responsibilities of consequences that may result from the procedures.
1.5 To verify that the patient has been clearly informed regarding the nature of the procedure or the treatment to be undertaken, the risks and benefits of the treatment, alternatives and options to consider and the expected outcome if the treatment is declined.

## 2. DEFINITONS:

2.1 **General Consent** – this provides the hospital with authorization for medical treatment, investigations and proves that the patient is aware about his rights and responsibilities and that the hospital shall not be liable for loss or damage to any personal property or valuables unless deposited for safe keeping.
2.2 **Informed Consent** – informed consent stems from the legal and ethical rights, where an individual has to decide what is allowed to do with his or her body. It is the physician's ethical duty to make sure that individuals are involved in decisions about their own health care. The process of securing informed consent has three phases, all of which involve information exchange between doctor and patient and are part of patient education. First in words (if an individual can understand), the physician must convey the details of a planned procedure or treatment, its potential benefits and serious risks and any feasible alternatives. The patient should be presented with information on the most likely outcomes of the treatment. Second, the physician must evaluate whether or not the person has understood what has been said, must ascertain that the risks have been accepted and that the patient is giving consent to proceed with the procedure or treatment with full knowledge and forethought. Finally, the individual must sign the consent form, which documents in generic format the major points of consideration. The only exception to this is securing informed consent during extreme emergencies.
2.3 **Emergency Situation** – an emergency is defined as a situation where a proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain consent would jeopardize the life, health or safety of the person affected.

## 3. POLICY:

3.1 A general consent form will be signed by any patient initiating a file in the Maternity and Children Hospital, Hafer Al Batin.
3.2 Each patient, admitted to Maternity and Children Hospital, Hafer Al Batin should sign the general consent as a part of admission process.

3.3 In case of emergency, procedure shall follow the emergency consent/ patients unable to give consent stated here with.

3.4 It is the policy of Maternity and Children Hospital, Hafer Al Batin that the patient should be given the opportunity to give 'informed consent' prior to high risk treatments and procedures, photography of patients or situations when it is deemed advisable to have formal documentation of the patients consent for treatment, with exception of emergency or trauma.

3.5 It is the right of the patient and the policy of Maternity and Children Hospital, Hafer Al Batin, that the patient may either accept or refuse the treatment offered to him/her.

3.6 The information provided should include the nature of the disease and of the proposed procedure or treatment, their significant benefits, risks and discomforts, alternate forms of intervention and their risks and benefits, as well as risks and benefits of foregoing all interventions.

3.7 It is the responsibilities of the attending physician, within his scope of practice, and according to guidelines of informed consent, to obtain an informed and valid consent from the patient before any procedure/ treatment be initiated.

3.8 In all surgical procedures, the most responsible surgeon who is to perform the operation, shall participate in person as a member of the operating team and should be present during the critical time of the procedure. Such participation shall not be delegated without the informed consent of the patient's authorized representative.

3.9 The patients must fully understand the information they have been given, must be competent to give consent and the signature should be witnessed by a responsible adult.

3.10 Documentation of the informed consent and the informed consent discussion must be completed in patient's medical records. The patient's record must indicate what was communicated, what risks/ benefits were discussed with the patient and if the patient had difficulty understanding the discussion.

3.11 All items on the consent form must be completed, signed, witnessed, timed and dated according to the hospital policy.

3.12 Witness is required for all types of consent as stated in the forms needed.

## 4. PROCEDURE:

4.1 Upon patient admission, the authorized admission unit staff will inform the patient about the general consent statement in a language that he/she understands.

4.2 The patient has to sign the general consent, or in case that the patient is unable to give consent the responsible family member will be asked to sign the general consent.

4.3 The general consent form shall not be used in the place of the surgical, medical and interventional procedures consent form.

4.4 The surgical, medical and interventional procedures consent form will be used to document informed consent in the following conditions:

- 4.4.1 All surgical procedures requiring general anesthesia.
- 4.4.2 All procedures requiring local anesthesia.
- 4.4.3 All procedures requiring conscious sedation.
- 4.4.4 All surgical and endoscopic procedures which involve entry into the body, either through an incision, or through one of the body's natural openings.
- 4.4.5 Blood and blood products transfusion.
- 4.4.6 All tissue biopsies.
- 4.4.7 Fine needle aspiration.
- 4.4.8 Epidural injections and anesthesia.
- 4.4.9 All imaging examinations requiring contrast.
- 4.4.10 Any other procedures which require a specific explanation to the patient from the medical staff.

4.5 The physician who is responsible for performing the medical or surgical treatment or procedure has the responsibility of obtaining an informed consent from the patient or an authorized, empowered person capable of consenting on behalf of the patient.

4.6 A physician may, at his or her discretion, appoint another member of the healthcare team to obtain the patient's signature on the consent form, with the assurance that the physician has satisfied the requirements of informed consent.

4.7 The physician should provide the following information to the patient in terms the patient can understand.
- 4.7.1 Diagnosis
- 4.7.2 The nature and purpose of the proposed treatment
- 4.7.3 The prognosis of the proposed treatment
- 4.7.4 The risk and possible complications of the proposed treatment.
- 4.7.5 Reasonable alternatives to the proposed treatment including the option of No treatment.
- 4.7.6 Prognosis of alternatives including No Treatment.

4.8 The attending physician should ensure that he gets the consent from the right person as follows:
- 4.8.1 In shared decisions (e.g. sterilization by tubal ligation, hysterectomy and contraception), the husband's consent is mandatory.
- 4.8.2 Children : Guardian consent must be available in the following order
  - 4.8.2.1 Father
  - 4.8.2.2 Mother
  - 4.8.2.3 Adult brother (in order of seniority)
  - 4.8.2.4 Uncle (father side)
  - 4.8.2.5 Grandfather (father side)
  - 4.8.2.6 Uncle (mother side)
  - 4.8.2.7 Grandfather (mother side)
- 4.8.3 If the person can't sign his/ her name; then a thumb mark is an acceptable documentation for agreement.
- 4.8.4 Anesthesiologist and/or physician who will perform the procedure should explain the necessary information to the patient/legal guardian and document this is in the medical record.
- 4.8.5 Nurse: the nursing staff member should sign as a witness.
- 4.8.6 If translator participate in the process, the translator should also sign.
- 4.8.7 The date and time of witnessing, the signature is completed.

4.9 The physician must evaluate whether or not the person has understood what has been said, must ascertain that the risks have been accepted and that the patient is giving consent to proceed with the procedure or treatment with full knowledge and forethought.

4.10 The patient must sign and write his ID number where indicated in the consent form, which documents in generic format the major points of consideration. The only exception to this is securing informed consent during extreme emergencies.

4.11 In case the patient cannot sign the consent, it can be signed by the patient's next of kin on behalf of the patient with proper identification and clearly written name. The whole process should be witnessed by a nurse or other person.

4.12 If other than patient sign the consent, the reason should be documented (comatose, etc.)

4.13 Documentation must clearly indicate that the patient has had the opportunity to ask any and all questions he/she may have about the proposed anesthesia and/or procedure.

4.14 Documentation of the following should be made by the physician in medical record:
- 4.14.1 That the discussion was held with the patient.
- 4.14.2 That the informed consent was obtained.
- 4.14.3 Any special circumstances surrounding this consent.

4.15 The informed consent must be placed in the medical record.

4.16 The physician obtaining the consent must sign in the appropriate location/ column.

4.17 The nurse witnessing the signature of the patient signs the informed consent form as witness.

4.18 All persons, who will sign or countersign the general consent form/ informed consent form, must clearly write their names, date and time along with their signatures (relation with the patient in case consent is signed by the family member).

4.19 If a translator participate in the process, the translator signs in the form.

4.20 Third party consent for an incompetent or minor patient is to be obtained following the same procedure.

4.21 Witness to signature:

4.21.1 The patient signature on the consent form must be witnessed by a hospital employee (nurse or physician) who is not involved in the procedure. The witness signature on the consent form signifies only that the patient's signature is indeed his own.

4.22 Emergency consent/ patient unable to give consent: In the following situations no known guardian, comatose patient, mentally handicapped etc.

4.22.1 Electively, a committee should be formed by hospital administration to take decision regarding the said procedure.

4.22.2 In instances where the patient is unable to give consent and/or no guardian is ready available and treatment is necessary as an emergency life saving measure or to prevent loss of limb or body part, informed consent may be waived. The physician must be sure to document that the treatment and/or procedure is being performed as an urgent lifesaving and/or limb/body part saving measure. It is required to have signatures of two (2) physicians (preferably Muslims) documented in the medical record in order to perform the procedure. This apply only as an emergency measure , and requires that the attending physician documents the following in the medical record:

4.22.2.1 The nature of the emergency

4.22.2.2 The planned treatment and/or procedure

4.22.2.3 The potential harm to the patient if the emergency treatment and/or procedure are delayed/not done.

4.22.2.4 The inability of the patient to consent and

4.22.2.5 The unavailability of guardians/ family members to provide consent

4.23 Duration of the consent:

4.23.1 General consent for admission shall be VALID for the duration of the hospitalization. If the patient is discharged and needs to be re-admitted, a new consent form for admission must be obtained.

4.23.2 A procedure specific informed consent form is considered valid for two (2) weeks after the date of signature as long as the patient's condition has not changed mean time. The same consent form, however, cannot be re used for any other procedure.

4.24 Refusal of consent: An adult patient who is conscious and capable of making a medical decision has the right to refuse any surgical or medical treatment or procedure. This must be documented in the medical record of the patient.

4.25 Elements of informed consent:

4.25.1 Specifically, the anesthesiologist and the treating physician must disclose in a reasonable manner all significant medical information that the physician believes is relevant and material to making an informed decision by the patient. This information should be written in clear, simple and easily understood terms. This should include the following:

4.25.1.1 The nature of the patient's condition

4.25.1.2 The risk, complications and expected benefits or effect or anesthesia

4.25.1.3 The alternate choice of anesthesia

4.25.1.4 The proposed treatment, possible treatment alternatives, including no treatment.

4.25.1.5 The benefits of the proposed procedure as well as frequently occurring and significant risks of the proposed treatment ad alternatives.

4.25.1.6 The consequences of no treatment.

4.25.1.7 The individuals who will be providing treatment and the role of the others in providing the proposed treatment.

4.25.1.8 The patient or patient's next of kin should be given the opportunity to ask questions and receive additional information as requested and the physician should ensure that the patient understand the message.

4.25.1.9 The patient should also be advised that it is not possible to predict or guarantee results.

4.26 Situations need informed consent:

4.26.1 Informed consent should be obtained and documented in the following situations:

4.26.1.1 High risk treatment and procedures (see list of procedures for consent)

4.26.1.2 Refusal of treatment
4.26.1.3 Discharge against the medical advice

4.27 A procedure which may otherwise require informed consent may be performed without obtaining prior informed consent in an emergency when the patient is incapacitated and cannot make an informed decision, and the patient has a life or health threatening situation requiring immediate treatment such that any delay in treatment would likely result in death, deterioration or serious permanent impairment. In such case a consent will be by committee process consist of the treating consultant and one specialist and when possible the patient relation officer.

4.28 Role of the hospital in the informed consent process

4.28.1 Obtaining verification that consent has been obtained by the anesthesiologist and/or physician before the physician permitted to perform the procedure.

4.28.2 The hospital personnel may not answer patient's questions about the nature of the anesthesia and procedures and will refer those questions to the anesthesiologist or the treating physician to enable him/ her to provide an informed consent.

4.28.2.1 Verifies that a witness was present during the time that the patient received the information constituting the informed consent.

4.28.2.2 Verify that a witness was present during the time that the patient signed the informed consent

4.28.3 The hospital personnel must assure that the patient has been informed and can:

4.28.3.1 State the name of the treating physician or other practitioner who has primary responsibility for the patient care.

4.28.3.2 The patient will be informed about any professional relationship the responsible physician, health care practitioner, the hospital staff or the hospital has to another health care provider or institution that might suggest a conflict of interest.

4.28.3.3 Any relationship to educational institutions involved in the case of the patient

4.28.3.4 Any business relationships between the individuals treating the patient or between the organization and any other health care, services or educational institution involved in the case of the patient.

## 5. MATERIALS AND EQUIPMENT:

N/A

## 6. RESPONSIBILITIES:

6.1 Physician
6.2 Surgeon
6.3 Anesthesiologist
6.4 Nurse

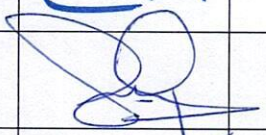
## 7. APPENDICES:

7.1 General Consent Form
7.2 Consent For Surgical, Medical and Interventional Form
7.3 COR-DAMA-367
7.4 Anaesthesia Sedation Consent
7.5 Consent for Blood Transfusion

## 8. REFERENCES:

8.1 Kingdom of Saudi Arabia, Ministry of Health, Baish General Hospital, Medical Staff and Provision of Care Policy, Version 1, 2018.

## 9. APPROVALS:

| | Name | Title | Signature | Date |
|---|---|---|---|---|
| **Prepared by:** | Ms. Rhodora Natividad | Document Management Control Coordinator |  | November 10, 2024 |
| **Reviewed by:** | Mr. Sabah Turayhib Al Harbi | Director of Nursing |  | November 14, 2024 |
| **Reviewed by:** | Mr. Abdulelah Ayed Al Mutairi | QM&PS Director |  | November 16, 2024 |
| **Reviewed by:** | Dr. Tamer Mohamed Naguib | Medical Director |  | November 17, 2024 |
| **Approved by:** | Mr. Fahad Hazam AlShammari | Hospital Director |  | November 24, 2024 |

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: رقم الملف الطبي:

Name: الاسم:

Nationality: الجنسية:

Age: _____ سنة Years ☐ شهر Months ☐ يوم Days ☐ العمر:

Date of Birth: ____/____/14____ H ____/____/20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

## GENERAL CONSENTS إقرارات عامـــة

| | |
|---|---|
| I (for Named Patient) signed below, authorize and give consent to my attending physician and/or his/her assistant to provide medical, nursing care and other clinical diagnostic or therapeutic procedures with the exception of surgical and invasive procedures, induction of anesthetics, infusion of blood and blood products and other procedures that require special consent. | أفوض أنا (المريض) الموقع أدناه، وأعطي موافقتي للطبيب المعالج ولمن يختار لمساعدته وذلك لتقديم عناية طبية وتمريضية وأي تشخيصات سريرية أو أية طرق علاجية بإستثناء العمليات الجراحية والإجراءات التداخلية حقن الدم أو مشتقاته أو أي عمل آخر يتطلب موافقة خاصة. |
| I understand that Dr._____ _____ is attending physician and is the person responsible for the assessment of my medical condition & my care plan & he/she will have the responsibility according to my medical condition, to Discharge or Transfer. | لقد تم إعلامي أن الطبيب المعالج د. _____ _____ هو الشخص المسؤول عن تقييم حالتي الطبية وخطة علاجي وتقع عليه/ عليها مسؤولية أمر خروجي من المستشفى أو تحويلي الى أية جهة عناية صحية أخرى وذلك بناء على ما تستدعيه حالتي الصحية. |
| I understand that the hospital and its employees will respect my rights and privacy at all times and that the confidentiality of my medical information will be guarded carefully and released only to authorized person. | أفهم وأعي أن المستشفى وموظفيه سوف يحترمون خصوصياتي في كل الأوقات وأن سرية المعلومات الطبية الخاصة بي سوف يحافظ عليها بعناية وسوف تستخدم فقط وحصريا لأجل العلاج وأن تعطى فقط لهولاء الأشخاص الذين يقومون على رعايتي. ولن يتم إعطاء المعلومات لاي شخص أو جهة إلا في حالة موافقتي الشخصية أو موافقة الشخص المصرح ليديل عني. |
| I shall abide by the hospital rules and regulations. | سوف التزم واطيع كل القوانين والنظم الخاصة بالمستشفى. |
| I understand that the hospital is not responsible for the loss or damage of my money, valuables and other personal property and that in case of emergency or no alternative situations the items should be handed over to the security for safekeeping. | أفهم إن المستشفى لا تتحمل مسؤولية فقدان النقود، المقتنيات الثمينة أو أية ممتلكات خاصة بي الا في الحالة الطارئة أو في حالة عدم وجود بديل للحفاظ على ممتلكاتي حيث ان هذه الممتلكات يجب أن تعطى لمسؤولي الامن في المستشفى للحفاظ عليها. |
| If it is found that I am not eligible for free treatment, I am obligated to pay for all services rendered as per my healthcare needs, I agree that the authorities and Kingdom's courts will decide any dispute in connection with such costs. | إذا اتضح إني غير مؤهل للعلاج المجاني فإني أتفهم إني مطالب بدفع كل المصاريف المتعلقة بعلاجي وأوافق أن الجهات المختصة والمحاكم بالمملكة العربية السعودية هي التي تقرر مسؤولية الدفع في حالة وجود خلاف حول المصاريف الواجب دفعها. |
| In case of emergency, where I am not coherent or conscious and unable to make my healthcare decision, I hereby grant the following person (s) the right to take decision of my medical treatment on my behalf: | إذا كان هناك طارىء أو حالة غيبوبة أو عدم تركيز وكنت غير قادر على إتخاذ قرار بشأن حالتي الصحية فأني أمنح حق إتخاذ القرار بالنيابة عني بشأن حالتي الصحية إلى الاشخاص التالية أسمائهم. |
| 1. Name: _____ Relation to the Patient _____ Date: ____/____/____ Time: _____ | الإسم: _____ صلة القرابة: _____ تاريخ: ____/____/____ وقت: _____ |

| Name: _____ الاسم: | MRN: رقم الملف الطبي: |
|---|---|
| I acknowledge that my signature on this form signifies that I am in agreement with all the statements.<br><br>Signature of Patient: _____<br><br>Date: ____/____/____ Time: _____ | أقر أن توقيعي على هذه الاستمارة يعني إنني موافق على كل بنودها وإنني قرأتها بالكامل قبيل توقيعي هذا.<br><br>توقيع المريض: _____<br><br>تاريخ: ____/____/____ وقت: _____ |
| **Substitute Decision Maker** | **من ينوب عن المريض (أو صانع القرار البديل)** |
| In case of emergency and the patient is unable to make decision and not granted any person to sign on his behalf.<br><br>Substitute Decision Maker Name _____<br><br>Relation to the Patient _____<br><br>Signature: _____<br><br>Date: ____/____/____ Time: _____<br><br>Reason for Patient not signing to Consent: _____ | في الحالة الطارئة وحين يكون المريض غير قادر على إتخاذ القرار ولم يمنح أحد حق التوقيع بالنيابة عنه.<br><br>إسم من ينوب عن المريض: _____<br><br>صلة القرابة: _____<br><br>التوقيع: _____<br><br>تاريخ: ____/____/____ وقت: _____<br><br>سبب عدم توقيع المريض: _____ |
| **In case of emergency and no Substitute Decision Maker** and patient not granted any person to sign on his behalf<br><br>We certify that, we have examined the patient and it is our professional opinion that this patient lacks decision capacity to take health care decision and any delay providing medical treatment will endanger his life or lead to serious body harm.<br><br>**1. Physician Name & ID No.:** _____<br><br>Position: _____ Signature: _____<br><br>Date: ____/____/____ Time: _____<br><br>**2. Physician Name & ID No.:** _____<br><br>Position: _____ Signature: _____<br><br>Date: ____/____/____ Time: _____ | **في الحالة الطارئة وغياب من ينوب عن المريض** وكون المريض لم يمنح أحد حق التوقيع بالنيابة عنه.<br><br>نحن نأكد ونوثق أنه عند فحص المريض وحسب رأينا المهني أن هذا المريض غير قادر على إتخاذ القرار بشأن حالته الصحية وأن أي تأخير في تقديم العناية الطبية اللازمة سوف يعرض حياته للخطر أو قد يؤدي الى عواقب وخيمة<br><br>**إسم الطبيب والرقم الوظيفي:** _____<br><br>وظيفته: _____ التوقيع: _____<br><br>تاريخ: ____/____/____ وقت: _____<br><br>**إسم الطبيب والرقم الوظيفي:** _____<br><br>وظيفته: _____ التوقيع: _____<br><br>تاريخ: ____/____/____ وقت: _____ |

**WITNESS** **شاهد**

| Name (الإسم) | Signature (التوقيع) | Date & Time (التاريخ والوقت) |
|---|---|---|
| 1.) | | |
| 2.) | | |
| 3.) | | |

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ سنة Years ☐ شهر Months ☐ يوم Days ☐ العمر:

Date of Birth: ____/____/14____ H ____/____/20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

## SURGICAL AND MEDICAL INTERVENTIONAL PROCEDURE إقرار الجراحة والإجراءات التداخلية

I, the undersigned _____

On my behalf _____

Here by authorize Dr.: _____ and his assistants to perform the following Surgical Operation Interventional Procedure: _____

_____

The physician has fully explained to me my condition, the reasons for the Medical Interventional Procedures/ surgery has also informed me of the expected benefits & complications, possible discomforts & risks that may arises as well as possible alternatives to the proposed treatment.

The procedure has been explained to me as above and I had the chance to have my questions and/or quires answered by my physician.
Main possible complications: _____

_____

Explained to me without any warranty or guarantee from the hospital's side as to the result or cure.

The treating physician or his assistants are entitled to provide additional procedures as reasonable and necessary, including administration of anesthesia and performance of pathology and radiology or excision of tissue / organ the surgeon deems necessary.

I do also authorize the hospital to keep, use or properly dispose any tissue and parts of organs that are excised during this procedure.

Signature of Patient or Guardian _____

Date ___/___/___ Time: _____

I have seen this consent before surgery and explained nature of operation to patient/ guardian.

Name of Doctor: _____

Signature: _____

Date: ____/____/_____ Time: _____

اقر أنا الموقع أدناه _____

بالأصالة عن نفسي أو بالنيابة عن: _____

بالموافقة على أن يقوم الطبيب _____

ومساعديه بإجراء العملية الجراحية /الإجراء التداخلي: _____

_____

قام الطبيب بشرح حالتي المرضية وسبب العملية الجراحية / الإجراء التداخلي والخيارات العلاجية البديلة المقترحة، وكذلك الفوائد العلاجية والمضاعفات والمخاطر المحتملة

وقد تم شرح العملية /الإجراء لي وأعطيت لي الفرصة للأسئلة وتمت الإجابة عليها بوضوح .

شرحت لي المضاعفات الرئيسة لمحتملة: _____

_____

دون تعهد أو ضمان من جهة الطبيب أو المستشفى فيما يتعلق بالنتيجة أو الشفاء .

وللطبيب المعالج أو لمساعديه الحق في اتخاذ مايرونه ضرورياً من الخدمات العلاجية الإضافية كاستخدام التخدير والأشعة والفحص الباثولوجي على سبيل المثال لا الحصر، أو استئصال أي نسيج أو عضو يرى الجراح ضرورة استئصاله أثناء العملية.

كذلك فإنني أفوض المستشفى بالحفظ أو التخلص المناسب من أي عضو أو نسيج تم استئصاله مني.

توقيع المريض أو ولي أمره: _____

التاريخ: ___/___/_____ الوقت: _____

اطلعت على هذا الإقرار قبل إجراء العملية الجراحية /الإجراء الطبي وقمت بشرح ذلك للمريض/ ولي أمره .

اسم الطبيب : _____

التوقيع : ختم:

اسم الشاهد: _____

التوقيع: _____

التاريخ: ___/___/_____ الوقت: _____

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ سنة Years ☐ شهر Months ☐ يوم Days ☐ العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

# DISCHARGE AGAINST MEDICAL ADVICE (DAMA)

**I, the undersigned,** _____ in my

Capacity as ☐ **Patient** ☐ **Legal Guardian** ☐ **Relative**

(Specify: _____) of

(Patient's Name: _____)

Hereby, I confirm that I have been advised by

**Dr.** _____ for the need to

Continue treatment at this hospital for myself / the patient and I also admit to the fact that the Doctor has explained to me the risks and the potential harms that may happen as a result of not continuing treatment or taking up the advice.

In spite of the above mentioned statement, I decided to discharge myself / the patient, on my responsibility and against the doctor's advice, decline his/her said treatment advice.

Therefore, I accept the full responsibility for my action and I release the hospital, the treating physician and other medical and nursing staff of any liability related to my action and to that effect I sign this consent in the presence of witness named below:

**Patient Name/Legal Guardian/The Next of Kin:**

_____

**Signature:** _____ **Date & Time:** _____

**I, Dr.** _____ confirm that I have advised the (Patient/Legal Guardian/Next of Kin) the need to continue treatment or taking the medical advice seriously.

Also the Health Care Practitioners and I tried the maximum efforts to convince the patient/legal guardian, and a next of kin to continue the treatment in another hospital or with another doctor of the same specialty to ensure a safe FOLLOW UP for medical condition for the patient. And I have explained the risk and potential harms and morbidity that may result from not continuing treatment or taking up the medical advice.

**Physician Name:** _____

ID No.: _____ Signature: _____

Date: ____ / ____ / ____ Time: _____

**Nurse/Witness Name:** _____

ID No.: _____ Date & Time: _____

**Administration On-Duty / Patient's Affairs Officer:**

Name: _____ ID No.: _____

Signature: _____ Date & Time: _____

**أنا الموقع أدناه:** _____ بصفتي

☐ **المريض/** ☐ **ولي الأمر/** ☐ **القريب**

**صلة القرابة:**(_____)

**اسم المريض:**(_____)

أقر بأن

الطبيب: _____ قد أبلغني إحتياجي / إحتياج المريض إلى ضرورة متابعة العلاج في هذا المستشفى وأقر كذلك بحقيقة أن الطبيب قد شرح لي خطورة عدم الاستمرار في العلاج, أو عدم الإنقياد للنصيحة الطبية والمخاطر الطبية المحتملة التي قد تنتج عن هذا الفعل.

وعلى الرغم مما ورد أعلاه فقد قررت الخروج/ إخراج المريض على مسئوليتي الخاصة ضد رغبة الطبيب معرضاً عن نصيحته الطبية.

وعلى ذلك أتحمل كامل المسؤولية عن تصرفي هذا , وأقر بأن المستشفى والطبيب المعالج وبقية أعضاء الفريق الطبي والتمريض المعنيين بحالتي معفيون من أية إلتزامات قانونية مترتبة على قراري هذا وعليه تم توقيعي على الإقرار في حضور الشاهد المذكور أدناه.

**إسم المريض/ولي الأمر/القريب:**

_____

**التوقيع:** _____ **التاريخ والوقت:** _____

**أنا, الطبيب:** _____ أؤكد بأني قد قمت بالنصيحة الطبية لـ (المريض) (ولي الأمر/ القريب) بضرورة إستمرار المريض في العلاج أو أخذ النصيحة الطبية بجدية.

كما قمت وكادر المستشفى بأقصى جهد ممكن لإقناع المريض/ ولي أمره أحد أفراد العائلة، من أجل متابعة العلاج في أية مؤسسة طبية أخرى أو عند طبيب مختص آخر لضمان سلامة الحالة ولقد وضحت الخطورة والمضاعفات الصحية المحتملة التي قد تنتج عن عدم استمرارية العلاج أو العمل بالنصيحة الطبية.

**اسم الطبيب:** _____

رقم الطبيب: _____ التوقيع: _____

التاريخ: ____ / ____ / ____ الوقت: _____

**إسم الممرض / الشاهد:** _____

الرقم الوظيفي: _____ التاريخ والوقت: _____

**المدير المناوب / موظف شؤون المرضى:**

الإسم: _____ الرقم الوظيفي: _____

التوقيع: _____ التاريخ و الوقت: _____

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KINGDOM OF SAUDI ARABIA

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Hospital: _____ مستشفى:

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Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

# ANESTHESIA / SEDATION CONSENT

**If you have any questions or concern about this Consent, ask your physician before signing.**

I, the undersigned: on my behalf / on behalf of: _____

_____

acknowledge that the anesthetist has discussed with me

the anesthesia method he/she will use for me which is suitable for my condition and its :

☐ General anesthesia ☐ Conscious sedation

☐ Regional anesthesia ( spinal or epidural )

Others_____

and he also discussed with me the other methods that could be used in case of any difficulty arises that prevent the using of the first choice anesthetic technique.

The anesthetist has explained to me the possible side effects and

complications of anesthesia and assured me that should any of these complications happen it would be dealt with promptly and effectively but without any guarantee of the outcome.

He also informed me about the precautions and instructions I have to follow before the operation.

إذا كان لديك أي تساؤل أو استفسار :يرجى سؤال الطبيب قبل التوقيع .

أقر أنا الموقع أدناه _____

بالأصالة عن نفسي أو نيابة عن _____

أن طبيب التخدير قد ناقش معي طريقة تخديري والتي تناسب حالتي وهي ☐ تخدير عام ☐ تخدير واعي

☐ تخدير ناحي ( شوكي أو فوق الجافية )

غير ذلك _____

كما ناقش معي البدائل المختلفة والتي من الممكن اللجوء إليها في حال حدوث صعوبات تمنع الخيار الأول للتخدير.

وشرح لي الأعراض الجانبية والمضاعفات المحتمل حدوثها نتيجة التخدير وأكد لي أنه في حالة حدوث أي من هذه المضاعفات (لا سمح الله) فإنه سيتم التعامل معها بحسم وفاعلية (حسب العرف الطبي) دون ضمان النتائج وأخبرني بالاحتياطات والتعليمات التي علي إتباعها قبل العملية.

## TO BE FILLED ONLY FOR HIGH RISK CASES :

The anesthetist has explained to me the high risk of anesthesia in my case due to :

A._____

B._____

C._____

Hereby in give consent to anesthesia knowing the high risk in my case.

## تملأ فقط في حالة الخطورة العالية

شرح لي طبيب التخدير وجود خطورة عالية بالتخدير في حالتي نتيجة وجود :

أ._____

ب._____

جـ._____

وأوافق على التخدير رغم علمي بخطورة التخدير على حالتي ولا أحمل الأطباء أي مسؤولية.

Hereby I, knowing all above, I authorize the anesthetists of the hospital to choose the technique (method) of the anesthesia; and to do suitable procedure to my case .

**Signature of the Patient or Guardian (Relation)**_____

**Name:**_____ Signature:_____

Date: ____ / ____ / _____ Time: _____

Name of the **Anesthetist:** _____

Signature: _____ Doctor's Stamp

Date: ____ / ____ / ____ Time: _____

وعليه ومع علمي بكل ما سبق أفوض أطباء التخدير في المستشفى باختيار طريقة التخدير واتخاذ الإجراءات اللازمة حسب حالتي

اسم وتوقيع المريض أو ولي أمره ( يذكر نوع القرابة :_____ )

الاسم :_____ التوقيع :_____

التاريخ ____/____/____ الوقت _____

اسم طبيب التخدير _____

التوقيع _____ ختم الطبيب :

التاريخ ____/____/____ الوقت _____

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MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____ / ____ / 14____ H ____ / ____ / 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

## CONSENT FOR BLOOD/BLOOD COMPONENTS TRANSFUSION موافقة على نقل الدم/ مشتقات الدم

I, the undersigned, _____ in my Capacity as

☐ Patient ☐ Legal Guardian ☐ Relative

(Specify: _____) of

(Patient's Name: _____)

That I have _____ I need the

Following units of _____

Since this will support the treatment of my condition.

It has been explained to me about the:

- Nature of the procedure.
- Benefits of this procedure.
- Risks involved with this procedure.
- Potential risks of not carrying out this procedure.
- Possible alternative treatment modalities.

**I knowledge that all relevant information about the procedure has been given to me in the language that I understand,**

**I have the opportunity to ask questions concerning me / my patient's condition and about the procedure and all questions have been answered to my satisfaction.**

**Patient's/Guardian's Name:** _____

**Relationship to patient:** _____

**Signature;**

**Date:** ____/____/____

**I have seen this consent before starting blood/ blood components transfusion and explained this to patient/ guardian.**

**Physician's Name:** _____

**Signature:**

**Stamp:**

**Witness's Name:** _____

**Signature:**

**Date:** ____/____/____

أنا الموقع أدناه: _____ بصفتي

☐ المريض/ ☐ ولي الأمر/ ☐ القريب

(_____) :صلة القرابة

(_____) :اسم المريض

اعاني من _____

وحاجتي إلى الوحدات التالية من _____

وذلك حسب حالتي المرضية كون هذا الدم سيساعد في التغلب على مرضي.

لقد تم الشرح التام لي عن مايلي:

- طبيعة الاجراء .
- الفوائد المرجوة من هذا الاجراء .
- المخاطر المرتبطة بهذا الاجراء .
- المخاطر المترتبة على عدم عمل هذا الاجراء .
- البدائل الممكنة للعلاج .

**وأقر بأن كافة المعلومات الهامة ذات الصلة بهذا الإجراء قد تم ايضاحها لي بلغة مفهومة من قبلي، كما اتيحت لي الفرصة لطرح الاسئلة التي تخطر لي / لمريضي، وأنه قد تمت الإجابة على جميع استفساراتي بصورة مرضية.**

**إسم المريض/ولي الأمر :** _____

**صلة القرابة:** _____

**التوقيع:**

**التاريخ:** ____/____/____

**اطلعت على هذا الإقرار قبل إجراء نقل الدم ومشتقاته وقمت بشرح ذلك للمريض/ولي أمره.**

**اسم الطبيب:** _____

**التوقيع :**

**الختم :**

**اسم الشاهد:** _____

**التوقيع:**

**التاريخ:** ____/____/____