ORTHOPEDICS AND TRAUMATOLOGY
INFORMED CONSENT FORM FOR SURGICAL PROCEDURES

Patient's Name:
Patient's Gender: □ F □ M
Passport No:
Patient Protocol No:
Date of Birth:
Birth Place:

Date:

Dear patients, please read this form carefully

1. INFORMATION RELATED TO SURGICAL PROCEDURES:

1.1. Diagnosis:...

1.2. Planned Treatment: ....

2. POTENTIAL COMPLICATIONS ASSOCIATED WITH THE PROCEDURE:

2.1. During the planned diagnostic or therapeutic procedure, medical devices such as X-ray, scopes, ultrasound, scintigraphy, computerized tomography, magnetic resonance imaging, etc. may be utilized; this may be associated with unpredictable consequences, including exposure to X-ray and other types of radiation; radiation exposure may result in supression of the bone marrow and anemia, compromise the immune system, affect the gonads and potentially result in infertility, and development of cancer on the long term,

2.2. As part of the planned procedure, blood and blood products may be used which may result in febrile reactions, blood reactions, shock, renal failure, suppression of the bone marrow leading to impaired hematopoesis, jaundice, and risk of transmission of infectious diseases, including AIDS, that may be identified early or late,

2.3. As part of the planned procedure, organ or tissue specimen may be harvested from a part of the body; temporary or permanent metal, synthetic, etc. foreign materials may be used fro outside the body; these materials may later become dislocated or rejected by the body, inflame, not perform the desired function, and additional surgeries may be needed to remove and replace these implants, and these surgeries are associated with additional risks and dangers,

2.4. Any diagnostic or therapeutic procedure may be associated with frequent anemia, infection, formation of a blood clot in the veins and lungs, bleeding from the surgical site or a distant location, allergic reaction, swelling of tissues (edema), epileptic seizures, temporary or permanent organ/system dysfunction, and death. Additional risks include: numbness at the incision site; permanent scar; deformation of the body due to removal or addition of a bone; personality changes; disability as a result of tissue or organ damage; life-long need to use medications/hormone replacements; short- or long-term pain and numbness in certain body parts due to patient positioning during a surgical procedure.

2.5. In addition to the general risks explained above, the planned ....
.... procedure may also be associated with potential risk and complications including the following:
....
....

....

....

3. RECOMMENDED TREATMENT/INTERVENTION CONSENT FORM

3.1. I have been informed about the diagnosis and treatment of my condition as well as the required anesthetic procedure / medical-surgical treatment and intervention.

3.2. I hereby acknowledge and agree that any additional intervention to those specified herein will be performed solely to prevent significant harm to my health and to save my life.

3.3. I have been informed about possible complications and risks.

3.4. I have been informed about other life-threatening risks that may emerge if I refuse these diagnostic and therapeutic procedures, if any, that can replace this form of treatment.

3.5. I have been informed that other interventions/medical treatments may be needed in case complications listed above develop (Section II) and that in some cases the process may not lead to full recovery.

3.6. Orthopedics And Traumatology Surgery is carried out within the scope of the facilities provided by Ankara University Faculty of Medicine and the patient's health insurance (Social Security Institution, Pension Fund and Social Security Organization for Artisans and the Self-employed) and their own financial means. Drugs and medical materials that are not available at the pharmacy of the hospital must be covered by the health insurance, the patient and his/her family within the valid protocols.

Patient's Name and Surname	*Republic of Turkey Identity No/ Passport No*	*Date/Hour*	*Signature*
Address:			
Phone No:			

FOR PATIENTS WITHOUT LEGAL CAPACITY: This section shall be filled out by the Patient's Natural / Legal Guardian

Legal Representative Name and Surname	*Republic of Turkey Identity No/ Passport No*	*Date/Hour*	*Signature*
Address:			
Phone No:			

PHYSICIAN PROVIDING THE INFORMATION:

Institution Doctor Name and Surname:	*Diploma No*	*Date/Hour*	*Signature*