Rīgas Dzemdību nams Ltd.
Reg. No. 40003194600

THE PATIENT'S INFORMED CONSENT TO MEDICAL CARE

Name, surname of the patient_____

Personal identity number or date of birth (dd.mm.yyyy.)_____

The medical card number of the inpatient or outpatient_____

With my signature, I attest that:

- I have received, in a timely manner, complete, precise and thorough information from the medical personnel of *Rīgas Dzemdību nams* concerning the objectives, risks and outcomes related to the medical treatment, and, after having received the above-mentioned information and explanations, I voluntarily consent to the necessary examinations, methods of treatment and the potential medical manipulations;
- I can express my own will, and I have provided all the essential information about the health of my child or my own health, in a truthful manner and in as much detail as possible, and I have answered the questions raised to me, and have received answers to the questions raised by me;
- I understand that during my presence at *Rīgas Dzemdību nams*, there may arise a situation wherein certain urgent actions may need to be taken to save or maintain my life or the life of my child, which may not be coordinated with me, but instead carried out following the medical opinion of a doctors' council;
- I am informed about my rights and about the possibility of refusing treatment or certain treatment methods, by signing the withdrawal form drawn up and approved by *Rīgas Dzemdību nams*;
- the potential risks and benefits of blood component transfusions have been explained to me;
- if there shall arise a need for the transfusion of blood components during my treatment, or during the treatment of my child, I consent / do not consent to the transfusion of blood components (please circle the appropriate option).

Patient/legal representative of the patient or the child_____
(signature, name, surname)

The information has been provided by a medical practitioner: _____
(occupation, name, surname and signature of the medical practitioner)

In the year of 202__, month: ____, day: _____, time: _____

After having received the necessary information and explanations, I voluntarily agree:

- **to a surgery**:_____
(the type and extent of the surgery shall be entered by the attending physician; also indicate the signature, name and surname of the attending physician)

and, if necessary, to a potential change in the type or extent of the surgery shortly before the surgery or during the surgery due to legitimate and medically justified reasons.

Patient/legal representative of the patient or the child:_____
(signature, deciphering of the signature, date)

- **to a determined type of analgesia/anaesthesia**: _____
(entered by the anaesthesiologist; also indicate the signature, name and surname of the anaesthesiologist)

and, if necessary, to a potential change in the chosen method due to legitimate and medically justified reasons.

Patient/legal representative of the patient or the child: _____
(signature, deciphering of the signature, date)

- **to a blood component transfusion:** _____
(the attending physician; also indicate the signature, name and surname of the attending physician)

Patient/legal representative of the patient or the child:_____
(signature, deciphering of the signature, date)