GENERAL CONSENT

Undersigned #!NEV; born.: #!SZULIDO;; I have recourse to the aid of the Emergency Health Care Department because of acute health problem. I know that in order to establish the diagnose, to treat me appropriately and to restore my health state, health personnel need exact information concerning my present complaints, my previous illnesses, their way of treatment, and during my treatment, it will be necessary to perform some interventions as well.

1. HEALTH CARE

	Medical examination.	Possible complications
Exam.	**Laboratory testing** from blood/urine.	Injuries of vascular, nerve, mucous membranes, bleeding, infection, allergic reaction, in extreme cases circulatory standstill can occur.
	Microbiological testing; samples collected from different parts of the body or from secretions.	
	Imaging examinations (ECG, US, X-RAY, CT, MRI, Endoscopy)	
Interv.	**Respiratory interventions** (O_2 mask, instrumental ventilation in non invasive mask, or in invasive way, through a tube)	
	Intravenous access, intravenous infusions, plasma substitutes, administering blood, blood preparations, medicaments.	
	Arterial access, direct monitoring of blood pressure.	
	Gastric irrigation, insertion of a stomach probe, purgation.	
	Bladder tapping, insertion of a permanent catheter.	
	Wound care, excision, suturing.	

The above listed examinations, interventions will be performed only in case of urgency, done professionally and carefully by specialized teams ready to prevent possible complications. More complicated **invasive** interventions are performed only after receiving patient information and signature of the patient's consent. In case of life-danger, there is no alternative solution.

2. DATA PROTECTION

	yes	no
I give my permission to inform those interested about the fact that I am hospitalized, and about the name of the department where I am treated.		
My close relatives can look into my health documents.		

I give my consent, for the staff to take photographs or video recordings for teaching purposes during the interventions under the reservation that my personality should not be recognizable.
I have understood all the above mentioned, I have received satisfactory answers to my questions, therefore, I give my consent to my examination and primary care. Except for:___________________________________

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3. OTHER

Safeguarding	I REQUIRE	I DO NOT REQUIRE
My closest relative	Name: Phone:	

4. Hereby I declare that I have received the information on the rules of medical data management put down in the Act XLVII., 1997 on Medical Data Management and I do not protest against the access to my data.

Sopron,

______________________________	______________________________
Signature of the physician giving the information	Signature of the patient, legal representative the authorized person