SPORT MEDICA S.A.
NZOZ CAROLINA MEDICAL CENTER
Hospital Register (Book) No.000000024799
78 Pory Street, 02-757 Warsaw
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CAROLINA medical center GRUPA LUXMED

PATIENT CONSENT TO INTRAARTICULAR AND PERIARTICULAR INJECTION OR/AND PUNCTURING

Patient's card number……..

Patient's name and surname……

Date of birth…… Statistical number (PESEL – if applicable) ……..

I give my informed consent to intraarticular / periarticular injection or/and puncturing of the joint:

……

lp.	*Medication name and serial number*	*Dose of the medication*
1.		
2.		
3.		

1. I confirm that I have read and understood received information on the type of procedure, purpose, method of performance, potential risks and complications that may occur in connection with performing the procedure (listed below) and how to proceed after its completion. Potential risks:
   - the administration of microorganisms into the body may cause infection,
   - the administration of medication into the body may cause allergic reaction,
   - during the intramuscular injection the drug can get into the bloodstream,
   - during the intramuscular injection the drug can get into the adipose tissue or subcutaneous tissue
   - during the intravenous injection there is a risk of introduction of oxygen into the bloodstream, which may cause air embolism,
   - during the intramuscular injection there is a risk of nerve damage.
2. I acknowledge that any surgery involves the risk of complications (including major), which can occur even when performed with due diligence and with the use of current medical knowledge.
3. I declare that I have given comprehensive and accurate information about current status of my health. I am aware that failure to provide or providing false information may have a negative impact on my health.
4. I declare that I have had unlimited opportunities to ask questions and I have received comprehensive answers and explanations to all my questions.

Based on the above, I give my informed consent / I do not give my consent to perform the procedure.

……
Date and legible signature of the **patient**

……
Date and legible signature of the **legal guardian** [1]

Doctor's statement on information given to the patient

I confirm that the patient has been informed about the planned procedure, its purpose, the course of the procedure and complications that may arise as a result of the procedure as well as during the accompanying medical procedures.

……
*Date, stamp and signature of the **doctor***

……., date……

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DECLARATION ON HANDLING AND PROPER STORAGE CONDITIONS OF THE MEDICATION, AND PERMISSION TO ITS APPLICATION AND POSSIBLE DISPOSAL

Patient's name and surname ……

Statistical number (PESEL – if applicable) or date of birth ……

I hereby agree to administration of the medication I provided to me / my underage child * by the doctor / nurse at the clinic / ward:

Lp.	Medication name / No.	Amount of administered drug	Expiry date
1			
2			
3			
4			
5			

I also declare that:

- I kept the above medicinal product in accordance with the manufacturer's instructions
- I received accurate information from the doctor / nurse regarding the possible consequences of giving me / my underage child * product that has not been stored in accordance with the manufacturer's instructions.

Legible signature of the patient ……

Legible signature of the person receiving the statement ……..

DECLARATION ON HANDLING

I hereby deposit the above-mentioned drug and simultaneously I agree on the utilization of the above-mentioned drug in case of expiration.

Date of delivery of the medicinal product ……

Legible signature of the person receiving the medicinal product……

Legible signature of the patient ……

* **Delete as appropriate**