

Emergency Clinical Hospital for Children of Cluj – Napoca
INFORMED CONSENT OF THE PATIENT / PARENT / LEGAL REPRESENTATIVE

Unit/Department: _____

<p>Data of patient / parent / legal representative /: I, the undersigned _____ residing in _____ legitimized with the Identity Card series ____ No. _____, as:</p> <p><input type="radio"/> patient (only in the case of the adult patient)</p> <p><input type="radio"/> parent of the patient _____ with the age of __ years __ months, Personal Identification Number of the patient _____</p> <p><input type="radio"/> legal representative of the patient _____ with the age of __ years __ months, Personal Identification Number of the patient _____, supporting evidence of the legal representative (for example: power of attorney No. _____)</p>

Declare that I have been informed by dr. _____ about:

Medical act (description): _____		
Recommended surgical operation: _____		
1. I have been provided with the following information regarding the medical act (to be filled in as this information is available):		
<input type="checkbox"/> Data concerning the health	yes	no
<input type="checkbox"/> Diagnostic assumptions / Diagnosis	yes	no
<input type="checkbox"/> Prognosis	yes	no
<input type="checkbox"/> Nature and purpose of the proposed medical act	yes	no
<input type="checkbox"/> Interventions and therapeutic strategies proposed	yes	no
<input type="checkbox"/> Benefits and consequences of the medical act	yes	no
<input type="checkbox"/> Potential risks of the medical act (including infectious risk) and unpredictable risks (including the slightest risk of death) _____	yes	no
<input type="checkbox"/> Viable treatment alternatives and their risks _____	yes	no
<input type="checkbox"/> Risks of not undergoing the treatment	yes	no
<input type="checkbox"/> Risks of non-compliance with the medical recommendations	yes	no
2. Other information provided		
<input type="checkbox"/> Information about the medical services available	yes	no
<input type="checkbox"/> Information on the identity and professional status of the staff who will treat him/her * * identified in the medical table with the medical staff that cares for the patient	yes	no
<input type="checkbox"/> Information about the rules in the medical unit, which he/she must adhere to – Internal Regulation Policy for patient/parent/legal representative (received upon admission)	yes	no
<input type="checkbox"/> right to a second medical opinion	yes	no
3. If, during the therapeutic intervention, unforeseen situations and conditions arise, which require procedures that are additional to those described as being accepted by me (including transfusion), I accept that the designated doctor shall act based on his/her professional training accordingly, only if these procedures are absolutely justified for medical reasons and only in the interest of the patient and for his/her benefit.	yes	no

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Based on **Law No. 46 of 21st January 2003** (*updated*) and **Order No. 1.410 of 12th December 2016** regarding the approval of the Details Rules concerning the Law of patient's rights No. 46/2003



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<p>4. I have been informed that the healthcare process is doubled by the educational process and I agree, within the limits imposed by decency and common sense, to participate in the educational process, including in terms of visits and small manoeuvres performed by the training personnel, as long as it does not affect the quality of the medical care. I have been informed that I can refuse this in principle or at the times that I choose, without having to give other explanations and without affecting my rights as patient.</p> <p>I agree with the participation in the medical education, the conduct of the medical consultation for teaching purposes by the staff in the educational process and for the specialised information about the health status to be used in the education and research process.</p>	yes	no
<p>5. I agree that the results of the tests performed to establish the diagnosis and treatment of the current disease will be used for any scientific studies developed within the clinic, respecting the right to confidentiality of the patient.</p>	yes	no
<p>6. <i>Following your consent, a few ml of blood will be extracted through a venipuncture will be performed to the child, using a needle that will be inserted into a vein. The area where the puncture will be performed will be carefully disinfected with alcohol. Only sterile and disposable instruments will be used, and the procedure, which will take several minutes, will be performed by specialised medical staff. For your own safety as next of kin, considering the emotional involvement, in some cases, we recommend that you do not assist in these blood drawings during this procedure. There are some situations in which the young patient, who requires such blood drawings, needs a slight immobilisation performed with the help of the auxiliary medical staff or, in selected cases, with the help of one of the parents – this immobilisation is necessary to avoid hurting the child and to perform the drawing as quickly and safely as possible for the patient. Upon contact with the medical staff or when seeing the needle or when the venipuncture is performed, the child may become agitated, and as a result of the pain felt by the sting and the emotion, some children may even show fainting (lipothymy: being sick, blurry vision, passing disturbance of the consciousness, pallor, sweating, lasting for several minutes, after which the patient recovers). There is also the risk of a minor bleeding at the puncture site and the formation of a hematoma (bruising). There is very rarely the risk of a local infection: sometimes, the vein that was stung becomes painful and/or the area turns red. In all these situations, maximum care will be taken in order to minimise any complication. Exceptionally, depending on how the laboratory works, you may be asked for a new blood drawing. Also, considering the young age, the presence of fever or other changes of the child's disease, it is possible that the blood drawing may not be successful at the first attempt and may require repeated punctures of the veins, sometimes another nurse may be called for help. However, we make sure that these repeated punctures will be performed on the same day only if the tests are necessarily required (for example, the severity of the case, the need to establish the emergency treatment, etc.) and with the utmost attention to minimise the discomfort of the child.</i></p> <p>I agree with performing laboratory investigations for the patient to specify the diagnosis (as the case may be):</p>		
<p><input type="checkbox"/> venous blood drawing (if necessary with peripheral venous catheter mounting), arterial or capillary</p>	yes	no
<p><input type="checkbox"/> pharyngeal and/or nasal exudation collection</p>	yes	no
<p><input type="checkbox"/> sputum collection</p>	yes	no
<p><input type="checkbox"/> collection of collections: auricular, conjunctival, vulvar, wound</p>	yes	no
<p><input type="checkbox"/> urine collection</p>	yes	no
<p><input type="checkbox"/> stool collection</p>	yes	no
<p>I agree with keeping the biological products and using them for any further tests.</p>	yes	no
<p>7. I agree with performing non-invasive examinations for the patient to specify the diagnosis:</p>	yes	no
<p>8. <i>If the intravenously administration of medicines is made repeatedly, for a longer period of time, then it is necessary to insert an IV - a sterile, disposable tube that is mounted inside a vein. Considering the young age, the presence of fever or other changes of the child's disease, it is possible that the insertion of this IV may not be successful at the first attempt and may require repeated punctures of the veins, sometimes another nurse may be called for help. However, we make sure that these repeated punctures will be done with the utmost care to minimise the discomfort of the child.</i></p> <p>I agree to and accept the treatment administrated through the pathways indicated by the doctor: digestive (oral - including by nasogastric sample test; rectal - suppositories, solutions), respiratory (aerosols), nasal (nasal drops), ocular (drops in the conjunctival sac), cutaneous (creams, ointments), injectable (subcutaneous, intradermal, intramuscular, intravenous, vaccination); enteral nutrition by the nasogastric tube, parenteral nutrition. Where appropriate, I agree with performing the psychiatric diagnosis and the</p>		

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speech-language evaluation and I accept the clinical intervention of the psychologist and/or kinetotherapy/physiotherapy manoeuvres.		
9. I have been informed that any medicine can have adverse effects, some of them are common, others are rare, some of them are mild, others are severe. In the case in which I accompany my child during the hospitalisation, when new manifestations appear after the start of a medication, I admit that it is my responsibility to immediately notify the attending physician - or on-call doctor or nurse to tell me if these manifestations are related to that medicine, what should be done next and what are the therapeutic alternatives.	yes	no
10. I mention that I have told the doctor about all the medicines that the patient has at this moment as treatment, prior to this hospitalisation (including anticoagulant or platelet aggregation inhibiting medication) and these are: _____ _____ _____		
11. Performing radiological investigations	Date of consent	Signature
1. Radiography		yes no
2. Computerised Tomography		yes no
3. MRI		yes no
4. Others _____		yes no
12. Performing invasive therapeutic or investigative procedures	Date of consent	Signature
1.		yes no
2.		yes no
3.		yes no
13. I have been informed that the Consent for a certain procedure/manoeuvre can be withdrawn by me at any time of the hospitalisation (before the procedure/manoeuvre) and I will take the risks deriving from this decision.	yes	no
14. The patient / parent / legal representative wishes to be further informed about the health of the patient.	yes	no
15. I agree with the fact that the health information and the medical data of the patient will be communicated to the persons listed below, this being my wish, expressed with full knowledge of the facts: Last name and first name of the person / persons indicated by the Grade of the person patient / parent / legal representative (family relationship/other relationship)		
1.		
2.		
3.		

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INFORMATION NOTE

In accordance with the requirements provided in Regulation (UE) 2016/679 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation), the Emergency Clinical Hospital for Children of Cluj Napoca processes in good faith and in accordance with the legal provisions in force your personal data, namely: your last and first name, address and personal identification number, telephone, mail, etc. (plus any other data you provide), intended for the provision of medical services.

We strictly observe and ensure professional secrecy, we respect the internal regulations on data protection. We only disclose the data for the fulfilment of your interests or the fulfilment of legal obligations. The confidentiality is for us not only a professional obligation, but also an essential value.

The purpose of data collection is in accordance with the provisions of the legislation in force. We review each year the data collected, by analysing to what extent their retention is necessary for the purposes mentioned, your legitimate interests or the fulfilment of the legal obligations by the hospital. The data that is no longer needed will be deleted.

Your personal data may, as appropriate, be transmitted to collaborators outside the hospital or to third parties. There is no other transfer of personal data to other recipients, unless we have this obligation by law (for example: processing made by financial and tax services, police, justice, social security). We use appropriate technical means to store the data safely. We do not process data for secondary purposes incompatible with the purposes for which we collected it.

You benefit from the right of access, intervention, deletion, rectification and porting regarding the data you provide to us. Note that there may be reasons preventing the immediate deletion of your data, for example, mandatory archiving periods, pending proceedings, claims, exercising or defending legal rights, etc.

I declare that I have been informed about the processing of my personal data by the Emergency Clinical Hospital in accordance with the provisions of the legislation (Regulation No. 679/2016) for the protection of natural persons with regard to the processing of personal data and the free movement of such data.

I certify that I have read, understood and fully accept the above and, as a result, I express my:

CONSENT

REFUSAL

for performing the medical act.

I undertake to inform the absent parent about this consent.

_____ Date: ____/____/____ Time: _____

Signature of patient / parent / legal representative

Signature of the doctor who made the information: _____

Table with the medical staff caring for the patient		
Crt. No.	Last name and first name	Professional status
1		
2		
3		

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I, **Andreea – Ioana AVĂDĂNEI**, English and French sworn translator and interpreter, based on the Licence No. 33337 of 29.02.2012, issued by the Romanian Ministry of Justice, hereby certify the exactness of the translation from Romanian into English, the text presented to me was translated completely, without omissions and, once translated, the document has not borne any change of its content and sense.

SWORN TRANSLATOR AND INTERPRETER,
Andreea – Ioana AVĂDĂNEI
(SIGNATURE AND SEAL)



Avădănei