VŠEOBECNÁ FAKULTNÍ NEMOCNICE V PRAZE
U Nemocnice 499/2, 128 08 Praha 2 | IČ: 00064165, tel.: 224 961 111

CONSENT TO HOSPITALIZATION*

First name and surname:		**Insurance ID #:**	

Dear Sir or Madam,
Welcome to the General University Hospital in Prague (thereinafter "Hospital"). We are ready to help you and make your stay and course of treatment easier.

I am aware that I am obliged to:

- adhere to the proposed individual treatment procedure;
- observe the internal regulations which I have been made acquainted with;
- observe the regimen of administration of medicinal preparations at the department, i.e. without the physician's knowledge and permission I cannot take any drugs I have brought with me. I will hand the drugs I have brought with me over to the health staff in the original packages so that the drugs will be administered only by the staff, and the rest will be returned to me on discharge;
- give the attending health care staff true information about the previous development of my state of health, including information about infectious diseases, about healthcare services carried out by a different provider, about the use of medicinal preparations, including the use of addictive substances, and further facts fundamental for the provision of health care;
- cover the Hospital's costs of the health care not covered or only partly covered by public health insurance or other resources, as I was previously informed of this fact and gave my consent to provision of the said health care.

The General University Hospital is an educational and scientific institution. Persons preparing for the medical profession (students, interns) perform their training under the supervision of health care professionals here. Their training is not possible without your cooperation. Therefore we ask you for your understanding, patience and consent so that these persons can inspect your medical records and be present while you are being provided with health care.
You are entitled to refuse your consent or you can revoke your consent at any time.

I consent to presence of medical trainees, including inspection of my records.	☐ **YES** ☐ **NE**

For scientific and training purposes it is necessary that the Hospital's health professionals have access to your medical records and can make necessary extracts and copies of it. Then the used data can only be published in an anonymized form, which will not allow revealing your identity. **You are entitled to refuse your consent or you can revoke your consent at any time.**

I give my consent to the said processing of my personal data.	☐ **YES** ☐ **NO**

I have been informed of the possibility of storing my valuables in the safe of the Hospital / the unit where I am hospitalized. I am aware that it is not possible for the unit to safeguard against theft, loss or damage my belongings that I did not hand over for safekeeping. If I keep these belongings on me, I undertake to look after them so that they will not be stolen, lost or damaged.
I also declare that the **electrical appliances I have brought** with me are in such condition that allows for their safe use and I assume liability for any damage, including injury to health caused by their bad function (shaver, hairdryer, radio, television, computer, phone charger, etc.).

I declare that I request that the **persons listed below** be authorised to:

1. get information about my state of health;
2. scrutinise my medical records (MR) and produce copies or extracts from them;
3. give or deny consent to provision of health services if I cannot do so due to my state of health (substitute consent).

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CONSENT TO HOSPITALIZATION*

First name & surname, relation to patient, contact Scope of information (all/specification of extent)	Getting information about the state of health (ad 1)	Scrutiny of MR (ad 2)	Copies, extracts (ad 2)	Substitute consent (ad 3)
	☐	☐	☐	☐
	☐	☐	☐	☐

Please specify in what way you / the person you appoint should be informed:	☐ **in person** ☐ **by phone, e-mail, text message, fax**
Communication password (which you will disclose to the appointed person yourself):	

☐ **I DISCLAIM** ☐ **I CLAIM**	getting **information** about my state of health.

In case I disclaim the option of getting information about my state of health I appoint the following person as one that should be given the information about my state of health:

First name and surname	**Relation to patient**

I forbid the following persons from getting information about my state of health:

First name and surname	**Relation to patient**

I have been intelligibly informed by the physician of the reasons for hospitalisation and considering the information provided I give my consent to hospitalisation. I declare that I have been made acquainted with the patient's rights, which I can request again from the nursing staff at any time during hospitalisation.

☐ I was instructed on the management of healthcare waste. I was provided with the "Patient Information Concerning the Management of Healthcare Waste" leaflet.

In Prague on:

.....	.....
Patient's signature/name and signature of guardian and guardian's relation to the patient/guardian's name and signature	Physician's signature / signature of the health professional

If the patient cannot sign the form due to the health state, state how he/she manifested his/her will:
