GENERAL UNIVERSITY HOSPITAL IN PRAGUE
U Nemocnice 499/2, 128 08 Prague 2 | ID: 00064165, tel.: 224 961 111

INFORMED CONSENT

Name and surname:	**National ID No.:**
Patient's legally acceptable representative (name, surname):	
Designation of the medical procedure/treatment procedure (or several procedures): ☐ **ADMINISTRATION OF A NON-AUTHORISED DRUG:** ☐ **ADMINISTRATION OF A DRUG INTENDED FOR USE IN A DIFFERENT INDICATION OR DIFFERENT AGE GROUP:**	
<u>Purpose, nature, preparation, expected benefit, consequences and possible risks of the medical procedure/treatment procedure:</u> The drug is not authorised by the State Institute for Drug Control or is authorised for a different indication or different age group, therefore consent to its application has to be signed. The administration of this medicinal product is fully indicated for you based on your medical condition. There is a possibility of the occurrence of some adverse effects that are stated in the information leaflet of this product.	
<u>Other alternatives of the treatment procedure, their suitability, benefits and risks:</u> In the Czech Republic there is no other available authorised medicinal product whose action would be equally beneficial for the patient.	
<u>The medical procedure/treatment procedure will take place as follows:</u> The medicinal product is administered: ☐ subcutaneously ☐ into a joint ☐ intravenously ☐	
<u>Restrictions and recommendations in lifestyle with regard to the medical condition and possible changes in medical fitness after the stated medical procedure:</u> There are no restrictions in your treatment regimen with regard to the application of the drug.	
<u>Further required treatment::</u> None	

This form is also directly available in the HIS.

INFORMED CONSENT

Name and surname:	**National ID No.:**

I declare that the doctor who instructed me personally explained the entire content of this written informed consent and I had the opportunity to ask him/her questions to which he/she gave a proper answer. I declare that I have fully understood the above instructions and information and give express consent to this medical procedure:

In case that the patient is **underage or has limited legal capacity** and is reasonably mentally and freely mature:

I declare that I have been instructed to the extent stated above.

If the patient was not provided with such data, he/she shall state the reason why:

In Prague on

....

patient's/legally acceptable representative's signature *doctor's name, surname and signature*

.....

signature of the underage patient/patient with limited legal capacity

If the patient/legally acceptable representative cannot sign because of his/her medical condition:

Reason why the patient/legally acceptable representative is unable to sign:

Manner in which the patient/legally acceptable representative expressed his/her will:

.....

name, surname and signature of the witness

This form is also directly available in the HIS.