FAKULTNÍ NEMOCNICE®
OLOMOUC

Zdravotníků 248/7, 779 00 Olomouc
Tel. 588 441 111, E-mail: info@fnol.cz
IČ: 00098892

Informed consent of a patient (legal representative) to hospitalisation

Patient – Name and surname:	Birth number (insuree No.):
Birth date: (if birth No. is not available)	Insurance company code:
Permanent residence address: (eventually another address)	
The name of the legal representative (guardian):	Birth number:

The reason for the hospital stay:

Statement:

I wish to be provided with information on my medical condition ***Note: Circle your answer***	YES	NO
If I accepted the opportunity to be clearly informed about my health condition in accordance with Sect. 31 (1) of Act No. 372/2011 Coll., I declare that I have been provided with the following information: - the cause and the origin of the disease, if known, its stage and expected development, - the purpose, nature, expected benefits, potential consequences and risks of the proposed health services, including individual medical procedures, - other possibilities for provision of health services, their suitability, benefits and risks for the patient, - other necessary treatment, individual treatment procedures, - restrictions and recommendations for lifestyle with regard to my health condition.		
I declare that I am familiar with the reasons for hospitalization, I regard the hospitalization information to be sufficient, I was able to ask about anything I did not understand or I considered to be important.		
I declare that I have not withheld any information known to me about my health to the physicians, which could adversely affect my treatment or endanger my surroundings, especially by spreading of communicable diseases.		
In case I do not want to be informed about my health condition, I appoint the following person to be given information about my health condition:		

Name and surname:	**Relationship to the patient:**

I declare that I have been informed about the internal rules of the University Hospital Olomouc, patients' rights and house rules.
I declare that I was informed by a physician about the possibility to access my medical records and making excerpts, transcripts or copies.*

I wish for another person(s) to be informed about my health condition during the hospitalization. *Note: Circle your answer:*			YES	NO
Name and surname	Address	Tel.		

I wish for the said person(s) to have the right to:		
a) access my medical records to make excerpts, transcripts or copies of my medical records*)	YES	NO
b) consent with the provision of health services, should I not be able to do so considering my condition, unless that type of health care services may be provided without consent	YES	NO

*) According to the Act No. 372/2011 Coll., Sect. 66, (3) a), a medical facility may request a payment for performing excerpts, transcripts or copies of medical records or other records, and the requested sum shall not exceed the costs associated with obtaining an excerpt or costs for performing a photocopy of medical records; the price list for excerpts or copies of medical records must be placed in a location accessible for patients.

Consent:

Note: Circle your answer:		
If necessary, I give my consent with the collection of biological material (blood, urine...) for the necessary tests to rule out especially transmissible diseases.	YES	NO
I agree with storing and using of biological material obtained in the course of normal diagnostic and therapeutic procedures for the needs of medical science and research, and with possible publication of the results in scientific journals while maintaining anonymity.	YES	NO

At the University Hospital Olomouc, there are physicians in the course of further education, students of the Medical Faculty, the Faculty of Health Sciences of Palacký University in Olomouc and students of medical schools preparing for the profession of medical personnel.

According to Sect. 46 (2) of the Act No. 372/2011 Coll., the University Hospital Olomouc is obliged to ensure that students and trainees are able perform professional practice and conduct activities, including medical procedures and medical records management. The education of students and trainees is carried out under the direct supervision of either a medical worker or a teacher for practical training.

Due to this reason, **I agree** that students and trainees access my medical records only to the necessary extent and on the basis of a mandate provided by a medical professional.	YES	NO
Furthermore, **I agree** with the presence of students and trainees during the provision of health care services.	YES	NO

I am aware and agree that if necessary, coercive measures may be used according to Act No. 372/2011 Coll., Sect. 39 (2), namely in the following situations:
- Only if the purpose of such use is to avert imminent danger to life, health or safety of the patient or others (e.g. condition after anaesthesia, surgery, procedure, etc.) and
just as long as the reasons for such measures last.

Date	Hour	**Signature of the patient or a legal representative (guardian)**

Name, surname of the physician providing the information	**Signature of the physician** providing the information

If the patient cannot sign, indicate the reasons for this limitation:			
The way the patient showed his/her will:			
Name and surname of the medical professional / witness	Signature of the medical professional / witness	Date:	Time

This consent applies to all transfers of the patient during one hospital stay in the University Hospital Olomouc.