Informed consent of the patient (patient's legal guardian) to pus drainage from an abscess

Patient – name and surname:	Birth registration number (insurance number):
Date of birth: (if no birth certificate number exists)	Insurance company code:
Patient's permanent address: (or other address)	
Name of legal representative (guardian):	Birth certificate number

Name of procedure

Drainage of pus from an abscess through a skin or mucous membrane incision

Purpose of the procedure

Provide drainage of pus.

Nature of the procedure

Surgical procedure (general or local anaesthesia, skin/mucosal incision, drainage of pus, drainage of abscess).

Expected benefit from the procedure

Elimination of problems: pain relief, improvement of swallowing and respiratory functions, elimination of inflammation.

Alternatives to the procedure

Puncture with a hypodermic needle – usually insufficient.

Consequences of the procedure

Scar at the incision site, impaired sensitivity or movement of the tongue/face, difficulty swallowing.

Potential risks of the procedure

Injury to a blood vessel – bleeding, risk of suffocation, need to secure the airway by cutting the trachea in the neck.

Consent:

Note: circle your answer:

I have been clearly informed about alternatives to the procedures performed at the University Hospital Olomouc, which I can choose.	YES	NO
I have been informed about the possible limitations of the usual way of life and work capacity after the respective medical procedure, and also about changes to health capability in the event of potential or anticipated health changes.	YES	NO
I have been informed about the treatment regimen and suitable preventive measures, and about control medical procedures.	YES	NO
I understand all the explanations and information, which I received from the doctor, and I have had the opportunity to ask additional questions, which were answered by the doctor.	YES	NO

After receiving the above explanations, I hereby declare:		
- that I consent to the proposed care and performance of the procedure and, in the event of unexpected complications, to the urgent performance of additional procedures, necessary to save a life or health.	YES	NO
- that I have been honest with my doctors and have provided them with all the information about my health, which was known to me and which could adversely affect my treatment or put anyone else at risk, in particular by the spread of communicable diseases.	YES	NO
- that if necessary, I consent to the sampling of biological material (blood, urine...) for necessary tests to rule out in particular, communicable diseases.	YES	NO

Date	Hour	Patient's / Legal representative's (guardian's) signature

Name and surname of the doctor who **provided the information**	Signature of the doctor who **provided the information**

If the patient is unable to sign, specify the reasons for which the patient was unable to sign:			
How the patient expressed his/her will:			
Name and surname of the healthcare professional/witness	Signature of the healthcare professional/witness	Date	Hour