(הסכמה לאשפוז– שפה אנגלית)

Psychiatric Unit

Consent form for treatment and hospitalization

.Form A

:To
Hillel Yaffe Medical Center Management

:I, the undersigned (the patient): Family name: _____ First name A.
_____

ID: _____ Address
_____

:Relative / guardian: Family name: _____ First name A.
_____

ID: _____ Address
_____

Statement

After I have been informed in a clear language the medical circumstances, medical treatment options, consequences that may incurred as result of the medical treatment in your .institution, I hereby consent to the required medical treatment

I consent that any doctor or other professional in the hospital will provide medical treatment and other treatments as required, or that treating hospital employee will finds necessary, appropriate and suitable to provide during the period of treatment and hospitalization, .under the circumstances of the illness

_____ Date: _____ Patient: _____ Relative / guardian
_____

_____ Signed in the presence of

_____ _____ :Title: _____ Name

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