OPTIMED	QUALITY MANAGEMENT DOCUMENTS OBSERVSTION HOSPİTALİZATİON TREATMENT CONSERT FORM	Doküman No:HD-FR-856 Yayın Tarihi :03.06.2025 Revizyon No :00 Revizyon Tar.:… Sayfa No :1/1

Patient Name – Surname: Date of Birth:

Date: Protocol No:

I consciously consent to the treatment to be administered by the physicians and medical team of the Private Optimed Hospital.

I have been informed about my illness and the treatment process. I allow the administration of all necessary medications, diagnostic tests, treatments, and interventions for the diagnosis and treatment of my condition. While I am hospitalized and undergoing treatment, I agree that any medication may be administered and samples may be taken for testing without prior notice by authorized doctors and medical staff. I have been informed that my treatment may involve injections, intravenous catheterization, and possible surgical/medical interventions, including associated risks and complications.

I have also been informed that diagnostic procedures such as X-rays, fluoroscopy, etc., may be performed and that I may be exposed to short- and long-wave radiation as a result. I consent to these procedures if deemednecessary.

I confirm that I understand the information provided to me and that the details in this form are accurate. I am aware of possible unforeseen negative developments and consent to undergo treatment at Private Optimed Hospital.

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Admission Department:

□ Emergency Service

□ ……

Patient Name – Surname:

Signature: Date/Time:

Legal Representative/Relative:

Name – Surname (Relationship: ……)

Signature: Date/Time:

Doctor Name – Surname:

Signature: Date/Time: