



Facility:

[Empty box for Facility name]

**KONSANTMAN JENERAL POU
TRETMAN
(GENERAL CONSENT FOR
TREATMENT)**

Chart No.

Name

Unit

(Patient Imprint Card)

FORM A

Pou pasyan ki bezwen sèvis pou pasyan ki entène lopital, pou pasyan ki pa entène lopital ak/oswa sèvis sal dijans. / For patients seeking in-patient, out-patient and/or emergency room services.

1. M ap mande pou m resevwa swen medikal ak tretman nan etablisman sa a e mwen dakò pou m aksepte sèvis ki ka dyagnostike yon kondisyon medikal, pwosedi pou trete kondisyon m nan ak swen woutin dantè ak medikal, e menm pou vaksinasyon. Mwen konnen ke se doktè, dantis, enfimyè praktisyen, fanmsaj, asistan medsen, ak lòt pwofesyonèl k ap bay swen sante, ak kèk nan moun sa yo ki anfòmasyon, ki pral banm sèvis sa yo. Yo pa banmwen okenn garanti sou rezilta sèvis mwen pral resevwa yo.
2. Mwen konnen ke akò mwen pou m aksepte sèvis sa yo pral rete anvigè amwenske mwen deklare mwen pa vle kontinye resevwa sèvis sa yo ankò oswa jiskaske tretman m nan fini.
3. Mwen konnen ke akò mwen pou m aksepte sèvis sa yo rele yon Konsantman Jeneral e ki li enkli nenpòt pwosedi woutin oswa tretman, tankou prelèvan san, egzamen fizik, administrasyon medikaman, fè radyografi, itilize anestezi lokal, ak nenpòt lòt pwosedi ki pa anvayisan.

_____ ak _____ am
Siyati pasyan an oswa paran/responsab legal pasyan ki se minè a **Dat** **(and)** **Lè** **pm**
(Signature of Patient or Parent/Legal Guardian of Minor Patient) **(Date)** **(Time)**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

_____ ak _____ am
Siyati reprezantan k ap pran desizyon sou swen sante a **Dat** **(and)** **Lè** **pm**
/responsab legal la (Signature of Health Care Agent/Legal Guardian) **(Date)** **(Time)**
(Place a copy of the authorizing document in the medical record)

_____ ak _____ am
Siyati ak relasyon de ranplasman **Dat** **(and)** **Lè** **pm**
(Signature and Relation of Surrogate) **(Date)** **(Time)**

TEMWEN (WITNESS):

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____ ak _____ am
Siyati ak tit temwen an (Signature and Title of Witness) **Dat** **(and)** **Lè** **pm**
(Date) **(Time)**

ENTÈPRÈT/TRADIKTÈ (INTERPRETER/TRANSLATOR): (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____ ak _____ am
Siyati entèprèt la/tradiktè a (Signature of Interpreter/Translator) **Dat** **(and)** **Lè** **pm**
(Date) **(Time)**