This form aims to raise your awareness about the issues related to your health and to provide your participation in the decision to be taken.

This form should not be considered as a document containing the risks of all forms of treatment although it is identified to meet the needs of many patients in many circumstances. Depending on your personal health condition, your physician may give you different or additional information.

It is up to you to decide whether or not to accept practices to be done after learning about the benefits and possible risks of surgical interventions, diagnosis, medical treatment. You may refuse informing except in cases of legal or medical necessity, or you may withdraw the consent at any time.

Information Regarding Procedure

Infection, clot formation in vein and lung, hemorrhage, allergic rection, heart attack, aeration deficit is lungs (atelectasis) and death may accur at the end of the all surgical, medical and/or diagnostic procedures. Also, there are risks regarding the intervention thet will be performed, written below; some of them are seen rarely.

Use of Assisted reproduction methods, creates higher risks for those who are with current disease (cardiac diseases, diabetes, high blood pressure, kidney disease, patients undergone kidney or liver transplantation, clotting and vascular disorders) and those who smoke. Apart from the specified ones, risks that are unique to use of Assisted reproduction methods; infection and/or abscess formation in abdominal or inguinal cavities (pelvic),over-stimulation of eggs due to used medications and hormones (ovarian hyper-stimulation syndrome) and related to this fluid collection inside the abdomen (ascites), fluid collection in lungs (pulmonary edema) and difficulty of respiration, intra-abdominal hemorrhage that is related to over-growing and tearing of eggs, which might require operation, deteriorated blood building-up of eggs by circulating around its vascular structures, which might require operation 8ovarial torsion), clot formation is veins (venous thrombosis), blood loss to the extent that requires blood transfusion, emergence of injury in majör veins of ovary, uterus and inside of the abdomen.

Also, on some patients, related to irritation caused in abdomen, inflammation of abdomen, retarded as peritonitis, and abscess formation may ocur after egg retrieval process from endometrioma (chocolate cyst) and similar structures, due to the infiltration of cyst content around the ovary and into the abdomen.

Diagnosis ……

Treatment/procedure to be applied ……..

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do mot accept the treatment, please declare so below with your hand writing.

……

I hereby declare that;

My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that is does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I will experience on the condition

that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered all my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healtcare professionals under the authority, surveillance and control of my attending physician.

I have been infomed thet if required, anesthesia will be performed by an anesthetist, sedation will be performed by an anesthetist or another physician competent in sedation and local anesthesia will be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team team will carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs remoted during the procedure for which I have consented above.

I allow my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

Patient's	Legal Representative's
Full Name:……. Date of Birt: ……/……./……. Date……/……../20…….. Time:…..:….. Signature:	Full Name:…….. Degree of Relationship:…….. Date……/……../20…….. Time:…..:….. Signature:
Reason why the consent is delivered by legal representative of the patient: ☐ Patient is not conscious ☐ Patient is not entitled to make decision ☐ Patient is under 18 ☐ Emergency	
Informing Physician's	Witness'
Full Name:…….. Date……/……../20…….. Time:…..:….. Signature:	Full Name:…….. Date……/……../20…….. Time:…..:….. Signature:
Interpreter's (If ruquired)	
Full Name:…….. Signature:	Date……/……../20…….. Time:…..:…..

Informed consent is delivered by the patient himslf/herself if s/he is order than 18 years old, by the patient himself/herself together with his/her legal representative if the ptient is aged between 15 and 148 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case emergency.