

CONSENT FORM – CSB

Universidad Francisco Marroquín  
Programa de Salud

Fundación Chusita Llerandi de Herrera  
Centro de Salud Bárbara

Facultad de Medicina  
San Juan Sacatepéquez

International Surgical Session from November \_\_\_\_ to the \_\_\_\_.

Patient Reference Sheet

I. General Information:

01. Full name\_\_\_\_\_

02. ID # (Cedula): Serie\_\_\_\_\_ Number\_\_\_\_\_ Issued in \_\_\_\_\_

03. Date of Birth: Day\_\_\_\_\_ Month\_\_\_\_\_ Year\_\_\_\_\_ 04. Age\_\_\_\_\_ Months Years

04 Gender: Male\_\_\_\_\_ Female\_\_\_\_\_ 05. Occupation\_\_\_\_\_

06. Residing in \_\_\_\_\_

07. Municipio\_\_\_\_\_ Departamento\_\_\_\_\_

Try to be very specific about where they live, in order to locate their relatives

08. Telephone number for relatives or neighbours\_\_\_\_\_

09. Does the patient read and write? NO\_\_\_\_\_ YES\_\_\_\_\_ Last level of education completed \_\_\_\_\_

10. Does the patient speak Spanish? Yes\_\_\_ No\_\_\_ Language Spoken\_\_\_\_\_

11. Initial Diagnosis\_\_\_\_\_

12. Other clinical data of interest will be specified on the other side of the page, or other pages will be added.

13. Make sure you mention any research or tests done.

13.1. Clinical Lab\_\_\_\_\_

13.2. Radiology\_\_\_\_\_

13.3. EKG\_\_\_\_\_

13.4. Other tests \_\_\_\_\_

14. Place, date and time to show up:

You must show up at Centro de Salud “Bárbara”:

Kilómetro 35,2. La Azotea, Carretera a San Raymundo, en San Juan Sacatepéquez

On the\_\_\_\_\_ day , of \_\_\_\_\_, 20\_\_\_\_.

Hour: \_\_\_\_\_ in the morning \_\_\_\_\_ in the afternoon.

15. Referred by \_\_\_\_\_ Telephone # \_\_\_\_\_

16. Information about the accompanying family member/friend.

16.1. Full name\_\_\_\_\_

16.2. ID Number (Cédula): Serie\_\_\_\_\_ Number\_\_\_\_\_ Issued in \_\_\_\_\_

16.3. Resides at\_\_\_\_\_

16.4. Telephone numbers: \_\_\_\_\_

16.5. Level of schooling\_\_\_\_\_

International Surgical Session from November \_\_\_\_ to the \_\_\_\_.

**Informed Consent Form for Patient who will undergo Surgery, in case of complications or other situations [sic].**

I, \_\_\_\_\_,  
Names and Last Names

\_\_\_\_\_  
Cedula #: Serie Number Issued in: Municipio & Departamento

Residing in \_\_\_\_\_,

in municipio \_\_\_\_\_, departamento of \_\_\_\_\_.

And of legal age, in good mental condition, I declare that I agree to undergo an operation; knowing fully well that should there be any sort of complication or problem detrimental to my health, during this Surgical session, which is organized for the health improvement of people and families of low income, and where I will be given generous specialized medical attention, as well as health care and humane and responsible treatment by all the staff. These are the reasons for which I take on all the necessary medical and legal responsibilities, and I shall never denounce or seek any sort of legal aid, or compensation before the authorities of my country, in case any complications may arise, derived from the treatment and the actions of the doctors or the staff who will take care of me during my time at the hospital and my recovery time. [sic again]

And, to vouch for my informed consent and the responsibility I take on, based on this document, I sign or provide my fingerprint to confirm my previous statement and to ratify my responsible commitment to my statement, so it is valid in face of any problem that may arise from this day and time on. [sic yet again]

San Juan Sacatepéquez, \_\_\_\_\_ of \_\_\_\_\_, 20\_\_\_\_ Time \_\_\_\_\_

Firma \_\_\_\_\_ Fingerprint \_\_\_\_\_

**Witnessed by:**

**Full name**

**Signature**

**ID # Serie and number**

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