პაციენტის წერილობითი ინფორმირებული უარი სამედიცინო მომსახურების გაწევაზე

Written Informed Refusal of the Patient to Continue Medical Services

2024 წელი

Written Informed Refusal of the Patient to Continue Medical Services

I, ---------- (Patient's Name and Surname),

Patient ID: ----------, Case No. ---------- Tel: ----------

By signing this document, I confirm that I have received complete information from the treating physician regarding the nature and necessity of the medical service, the risks and consequences related to this service for my health and life, financial and social issues, as well as the possible consequences of refusing treatment. Based on my free will, I wish to declare my refusal of the proposed treatment. I also confirm that I fully understand the potential illegal consequences of my actions and that I have no claims against "Tbilisi State Medical University and Ingorokva University Clinic of High Medical Technologies."

The patient has received answers to all their questions of interest and has been provided with complete information.

Treating Physician: ---------- Signature: ----------

Signature of the patient's relative/legal representative: ----------