ERCIYES UNIVERSITY
FACULTY OF DENTISTRY ORAL AND
MAXILLOFACIAL SURGERY HOSPITAL

PATIENT ADMISSION CONSENT FORM

Kalite Yönetim Sistemi
TS EN ISO/IEC 17021
AB-0022- YS

Patient Name Surname:

Date of Birth: ... / ... / ...

Gender : □ Female □ Male

Patient Registration No: Date :……/……/……..

Room No :

Preliminary Diagnosis:……..

…….

……

Planned Treatment: ……

…….

……..

Special Circumstances/Requirements that Need to be Notified: /:……..

Need for Accompanying Person:□ Yes □ No Estimated Duration of Stay: □Daycare □1-3 days □ 4 days and above

Forensic Case : □ Yes □ No

Attending Physician's

Name-Surname : Date:….. /……/……. Time:……..

Signature/Stamp : Phone:……

PATIENT CONSENT

I authorize the diagnosis and/or planned intervention/treatment specified above to be applied by physicians, nurses, and other healthcare professionals under the authority, supervision, and management of my doctor, in a manner appropriate for my illness and medical condition.

Patien's Name- Surname : …….. Date:…../……/…….
Signature Time:…….

Name-Surname of Patient's Legal Representative:…… Date:…../……/…….
Signature Time:……..

If consent is obtained from the patient's legal representative, please specify the reason /
□ Patient unconscious / □ Patient under 18 years old / □ Patient lacks decision-making capacity □ Emergency/

Explanation:

☐ Patients over 18 years old themselves
☐ Patients aged 15-18 themselves and additionally from their legal representative
☐ Consent is obtained from the legal representative of patients who are unconscious, under 15 years old, in medical emergencies, and lack decision-making capacity.

DISCHARGE INFORMATION AT THE PATIENT'S REQUEST

I reject the advice and recommendations of Dr. …… and leave the hospital, assuming responsibility for myself..

Patient's Name-Surname : …….. Date:…../……/…….
Signature Time:…….

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WELCOME

It is our primary duty to provide you with the most advanced technological facilities in medicine during your time with us.

There is a very close relationship between the quality of treatment provided to you and the discipline in the hospital operation. Therefore, we kindly request you to adhere to the hospital operational rules listed below and thank you for your attention and cooperation.

- VISITING HOURS at our hospital are from 13:00 to 14:00 every day. However, if deemed necessary by the clinical physicians, restrictions may be imposed on visiting hours.
- Visitation when there is a condition that may be detrimental to our patients is subject to physician approval.
- The duration of stay for visitors in patient rooms is limited to 20 minutes. ***SMOKING IS STRICTLY PROHIBITED*** inside the hospital for the health of our patients.
- Flowers are not allowed on the floors due to the risk of infection.
- No food/drink service is provided to visitors and attendants on the floor, and no food and drink should be brought from outside the hospital, even if in closed packaging. This decision is made by our hospital committees due to our meticulous service approach and medical reasons.
- During admission, all valuables should be handed over to the patient's own relatives. However, patients who do not have this opportunity can entrust their belongings to the responsible nurses of the ward against a record.
- The hospital administration is not responsible for items not delivered with documentation.
- Any questions or problems regarding hospital operation and order can be addressed to the "Patient Rights Unit".

WE WISH YOU A HEALTHY DAY …

I fully accept to comply with the operational rules listed above of Erciyes University Faculty of Dentistry Oral and Maxillofacial Surgery Hospital.

Patient's Name Surname : …….. Date:…../……/…….
Signature Time:…….

Name-Surname of Patient's Legal Representative:…… Date:…../……/…….
Signature Time:……..

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