

# Informed Consent Document

**WARNING.-** From the legal viewpoint, the following informed consent document is drafted with the basic aim of satisfying the requirements of (Spanish) Basic Law 41/2002, of 14 November, that regulates the Patient's Autonomy and the Rights and Obligations in terms of Clinical Information and Documentation. From the medical viewpoint, when selecting the models and describing the different risks and procedures, an attempt has been made to show the most frequent and the most important ones, although not claiming to be totally exhaustive. We remind you that this document cannot purport to be a substitute for adequate information provided by the doctor, which adapts to each specific case. The specific risks of each patient must also be taken into account, as well as the innovation imposed by scientific-professional progress in agreement with the recommendations of the different scientific societies of the speciality and the Health Authorities.

**INFORMED CONSENT DOCUMENT**

**INFORMED CONSENT DOCUMENT FOR TREATMENT WITH  
INJECTABLE ANTICOAGULANT (E.G. HEPARIN)**

MEDICAL RECORD No.....

Mr/Mrs/Ms ..... aged ..... years .  
(Patient's name and two surnames)  
with residence in ..... and National I.D.  
no. ....

Mr/Mrs/Ms ..... aged ..... years .  
Name and two surnames)  
with residence in ..... and National I.D. no. ....

as ..... of .....  
(Legal representative, relative or close friend) (Patient's name and two surnames)

**DECLARE**

That DOCTOR .....  
(Name and two surnames of the practitioner providing the information)

has explained to me that it is medically advisable for me, in terms of my specific case to receive ANTICOAGULANT TREATMENT WITH HEPARIN:

The main aim of this treatment is to prevent thrombosis or embolisms (obstruction of blood vessels) and their complications. It consists in subcutaneously administering an anticoagulant medication called heparin, and it may be necessary to carry out some periodic analytical controls. These controls are carried out by extracting blood and they enable the doctor to adapt the most adequate dose of heparin within the ranges that are considered advisable for my specific case.

He/she has also justified the general and specific reasons why this treatment can be beneficial for my health. In essence, being able to treat and actively prevent thrombosis and embolisms.

Furthermore, he/she has explained to me the risks that may derive from not receiving the anticoagulant treatment, which would be those derived from not acting against the thrombotic disease or not preventing it. Thrombosis and arterial embolisms produce the interruption of oxygenated blood circulation from one area of tissue or organ, finally causing infarct (cell death) of that area. The consequences of this are usually important permanent sequelae of a neurological, heart, lung type, etc. or amputations of limbs, and even resulting in death if severe lesions are caused to vital organs. In the case of prevention of venous thrombosis, the most frequent complications are rethrombosis, post-thrombotic sequelae (ulcers) and lung embolism, which might result in permanent lung sequelae or cause death.

He/she has also informed me about the possible alternatives to this treatment, explaining to me that as of today and at this moment in time there are no alternatives to anticoagulant treatment with better effectiveness and safety profile for my specific disease or risk.

Furthermore, he/she has explained that the treatment is not risk-free and he/she has clarified what these risks entail. He/she has informed me that this treatment reduces the ability to coagulate and thus entails a greater risk of suffering haemorrhages. Severe haemorrhages in vital organs that lead to hospitalisation, that produce sequelae or even death, are very rare. Other possible undesirable effects of anticoagulant treatment with heparin, although infrequent, are allergy to the medication (generally skin-related) and heparin-induced thrombocytopenia (reduction due to immunological cause of platelets that may be accompanied by thrombosis).

Furthermore, he/she has explained to me that, in my particular case, and bearing in mind my personal circumstances (age, previous health status, sex, race, profession, religious belief, etc.) the following additional risks exist: *(Fill in, if relevant, the particular risks that are presumed due to the patient's specific personal or medical conditions).*

# INFORMED CONSENT IN HAEMATOLOGY AND HAEMOTHERAPY

## CONSENT DECLARATION

All of these conditions have been assessed by my doctor before submitting me to this procedure. He/she has explained to me that they will perform all the tests and adopt all the necessary measures to reduce the risks described as much as possible.

I have also been informed of the possible consequences of not undertaking the treatment proposed to me.

I have understood the explanations that I have been given in clear and simple words, and the practitioner that has attended to me has given me the opportunity to formulate any observations that I consider appropriate, and he/she has cleared up all the doubts that I have set out.

I also understand that I may, at any time and without having to provide any explanation, revoke the consent that I now give.

To this end, I declare that I am satisfied with the information received and that I adequately understand the scope and risks of the procedure targeted by this consent.

And under these conditions

## I CONSENT

To receive the ANTICOAGULANT TREATMENT WITH HEPARIN.

In ..... (place and date)

Signed: The doctor

Signed: The patient

Signed: The legal representative,  
relative or close friend

## REVERSAL

Mr/Mrs/Ms ..... aged ..... years  
(Patient's name and two surnames)

with residence in ..... and National I.D. no. ....

Mr/Mrs/Ms ..... aged ..... years  
Name and two surnames)

with residence in ..... and National I.D. no. ....

as ..... of .....  
(Legal representative, relative or close friend) (Patient's name and two surnames)

I REVERSE the consent given on ..... and I do not wish to continue with the treatment, which, on this date, I considered as terminated.

In .....(place and date)

Signed: The doctor

Signed: The patient

Signed: The legal representative, relative  
or close friend