Maharaj Nakorn Chiang Mai Hospital

Faculty of Medicine, Chiang Mai University

110 Intawaroros Road, Chiang Mai 50200

Tel. 66-53-935601, 66-53-935603 FAX 66-53-221141

Consent for Diagnostic Procedures and Treatments

Name.....Hospital No.....Physician.....

This consent form attests that on (date).....at time.....

I.....Age.....Yrs. Nationality.....

do hereby authorize and give my informed consent to such diagnostic procedures/blood transfusion/ medical treatment as the physician at Maharaj Nakorn Chiang Mai Hospital deem necessary to **perform upon** me, or to the patient (name).....Age.....Yrs.

I acknowledge that no guarantee or assurance has been made to me as to the results of any diagnosis, treatment, tests, or examinations performed at Maharaj Nakorn Chiang Mai Hospital

I accept all of the risks that may result from the diagnostic procedures/blood transfusions/ medical treatments

I ☐ agree ☐ Not agree for Diagnosis Procedures and treatments

I-121-0011 ใบยินยอม

Signature.....Patient Signature.....Doctor

(.....) (.....)

Signature.....Witness Signature.....Witness

(.....) (.....)