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|  | FORM | CODE: | FT-AH-060 |
| | INFORMED CONSENT FOR NURSING CARE | VERSION: | 5 |
| | | ISSUANCE DATE: | 06/19/2018 mm/dd/yyyy |

Date: _____

Full name: _____

Date of birth: _____ ID No.: _____

I hereby authorize the nursing care required during my stay at the Clinica de Marly S. A. such as:

- | | Yes | N/A |
|--|-----|-----|
| 1. Bathing in shower or bed. | | |
| 2. Cleaning of room. | | |
| 3. Assistance during meals. | | |
| 4. Taking vital signs. | | |
| 5. Hemodynamic monitoring | | |
| 6. Use of bedpans and diapers. | | |
| 7. Skin care. | | |
| 8. IV access, change and removal. | | |
| 9. Care of central catheters. | | |
| 10. Wound care. | | |
| 11. Administering medications prescribed by the treating physician. | | |
| 12. Administering transfusions (except for patients from Jehovah Witnesses). | | |
| 13. Installation or removal of probes (nasogastric, vesical). | | |
| 14. Taking samples for paraclinical analysis. | | |
| 15. Liquid control (administered/removed). | | |
| 16. Education. | | |
| 17. Isolation of patients. | | |
| 18. Other as needed by patient and pursuant to medical instructions. | | |
| 19. Transfer in ambulance for imageology analysis as prescribed or special procedures. | | |
| 20. I have been informed that the locker is to be used exclusively for clothing and should not be used for any objects of value (wallet, money, jewelry, etc.) | | |

I understand and accept this document.

Signature and ID No. of patient

Signature and ID No. of patient's relative or guardian.

Signature and ID No. of Certified Nurse/CAN

Kindship: _____

This document shall be included in the Patient's Medical Record.