

CONSENT TO MEDICAL TREATMENT

I, _____ , acknowledge that I have received and read the leaflet
(name of patient)

entitled *Post-Exposure Prophylaxis – Guidelines for the Patient*. I also acknowledge

that Dr _____ has explained the potential benefits, the
(name of attending physician)

limitations, the possible side-effects, and the contraindications of the medications that are being

offered to me. I further acknowledge that Dr _____ has
(name of attending physician)

explained to me the modalities of the treatments.

Having understood all of the above, I accept to take:

(check mark to be made next to whichever treatment patient is accepting)

the so-called “**morning-after pill**”

the so-called “**post-exposure prophylaxis**”.

Signature of Patient

Place, date and time

Signature and name of person giving consent on behalf of the patient
(if patient is under the age of 18 or otherwise unable to give consent)

Place, date and time

Witness (signature and name)

Place, date and time