**GOVERNMENT OF NCT OF DELHI**

**MAULANA AZAD MEDICAL COLEGE**

**2-BAHADUR SHAH ZAFAR MARG: NEW DELHI-02**

### INFORMED CONSENT FORM

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,son/daughter/wife/friend/caregiver

of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a resident of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

do hereby declare that I give informed consent.

DR. Tejeshwar Singh Jugpal has informed me to my full satisfaction, in the language I understand, about the purpose, nature of study and various laboratory investigations to be carried out for the study. I have been informed about the duration of the study & possible complication caused by study.

I give full consent for being enrolled in the above study and I reserve my right to withdraw from the study whenever I wish, without prejudice of my rights to undergo further treatment at LNH/GB Pant/GNEC,New Delhi.

Signature or thumb impression Signature or thumb impression

of patient of patient’s relative.

Name: Name:

Date: Date:

We have witnessed that the patient and/or relative has signed the above form of his/her free will after fully understanding its contents.

Signature of the witness Signature of the Investigator

Name: Name:

Relation: Designation: