**مستشفي الملك فيصل التخصصي**
**مركز الإبحاث**
(مؤسسة عامة)

**KING FAISAL SPECIALIST HOSPITAL AND RESEARCH CENTRE**
(General Organization)

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عذرًا، لم يسبقني قراءة هذا النص بشكل طبيعي، وبالتالي لا يمكنني تقديم النص بشكل طبيعي.

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الم病

إذن خطي بالموافقة على العلاج:

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لا يوجد أي معلومات ملحوظة في السجل.

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المراجعات:

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المعلومات المتاحة:

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ال Điện: 0015-02 (Rev. 05-35)

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Front
Dear Patient:

To enable us to provide the best services and reduce the waiting time to the minimum extent possible, you are kindly requested to complete this form in order to help us finalize the necessary data in your medical record:

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Father's Name/Middle Name:</th>
<th>Grandfather's Name:</th>
<th>Family Name:</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Date of Birth (dd mm yyyy): Place of Birth: Age: Sex:

- ☐ Male
- ☐ Female

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

National I.D./Passport No./Iqama No.: Date Issue: Place of Issue: Nationality:

Mother's Name: Home No.: Mobile No.: Fax:

Business Address: Business Phone No.: Extension: E-mail Address:

P.O. Box: City: Zip Code:

Do you have an existing record at King Faisal Specialist Hospital & Research Centre: ☐ Yes ☐ No If yes, provide number:

RELATIVES TO CONTACT IN CASE OF EMERGENCY:

1. Name: Relationship: City: Mobile No.: Home No.:

2. Name: Relationship: City: Mobile No.: Home No.:

To finalize registration procedures, the patient's National I.D. or Passport should be presented.

CONSENT FOR GENERAL TREATMENT:

I hereby authorize the Hospital's Authorized Personnel to administer medical treatment and perform diagnostic tests as may be necessary or advisable.

I understand that the treating physician is the person concerned for the assessment of my medical condition and he/she will have the right for my discharge or referral and transfer from ward to ward or to any other health care facility based on my medical condition.

I understand that supervised medical students/trainees, may be involved in my care.

I understand that the Hospital and its employees will respect the privacy of patients at all times and the confidentiality of their medical information shall be guarded carefully.

All reasonable attempts have been made to provide me and/or my guardian with sufficient information concerning the benefits and risks of the treatment or investigations in order to permit informed consent.

I understand that the Hospital will accept for safekeeping money, valuables and personal property but they shall not be liable for loss or damage to any personal property or valuables, unless deposited with the Hospital for safekeeping.

I accept responsibility for all charges for hospital services, that are not provided free of charge as per hospital policy, including any charges not accepted by the guarantor or by the referring agency.

I agree that the authorized competent judicial authorities and Kingdom's Courts will decide any dispute in connection with such accounts.

Printed Names and Signatures: In case the patient's condition or age reasonably precludes the ability to grant informed consent, the above information has been explained to the following responsible relative and treatment is hereby authorized:

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Relative's Name:</th>
<th>Signature:</th>
<th>Relationship:</th>
</tr>
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Signature: Relationship: Date: Witness: / Signature: Date: