**Patient Consent Form**

**Cerebrolysin Treatment**

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**Patient Information**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction**

You are being asked to participate in a treatment involving Cerebrolysin, a medication derived from pig brain tissue. This form provides information about the treatment, potential benefits, risks, and your rights as a participant.

**Purpose of the Treatment**

Cerebrolysin is being used for its potential therapeutic effects on the brain and nervous system. This treatment aims to support neurological function, promote cognitive health, and improve quality of life in patients with various neurological disorders and cognitive impairments.

**Description of the Treatment**

If you agree to participate, you will receive Cerebrolysin according to the following protocol:

* **Dosage**: [Specify dosage, frequency, and route of administration]
* **Duration of Treatment**: [Specify duration]

**Potential Benefits**

The potential benefits of Cerebrolysin treatment may include:

* Enhanced cognitive function
* Improved mood and emotional well-being
* Increased energy and vitality
* Enhanced quality of life

**Potential Risks and Side Effects**

Possible risks and side effects of Cerebrolysin may include, but are not limited to:

* Mild headache
* Nausea or vomiting
* Dizziness or lightheadedness
* Injection site reactions (pain, redness, swelling)
* Allergic reactions (rash, itching, difficulty breathing)
* Changes in blood pressure or heart rate

**Voluntary Participation and Withdrawal**

Your participation in this treatment is voluntary. You have the right to refuse or discontinue the treatment at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw, you should inform your healthcare provider immediately.

**Confidentiality**

All information collected about you during this treatment will be kept confidential. Your identity will not be disclosed in any reports or publications resulting from this treatment.

**Alternatives**

If you choose not to participate in this treatment, your healthcare provider will discuss alternative treatment options with you.

**Consent**

By signing this form, you acknowledge that you have read and understood the information provided, have had the opportunity to ask questions, and agree to participate in the treatment with Cerebrolysin.

**Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Additional Information**

If you have any questions or concerns about the treatment, please contact:

**Healthcare Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_