Instituto Cardiovascular	**STITCH REMOVAL CONSENT**	**VERSION: 01** **COD: 02** **DATE:05/12/2024**

Date _____/_____/_____

I _____ Identified with CC **___TI___TE___ CE__ Passport___Other___ #_____from** _____ acting on his own behalf or _____ Identified with **CC___TI___TE___CE__Passport___Other___ #_____from_____** who am i_____ **I have been informed by_____, Job title_____**

I have understood what the **REMOVAL STITCH** procedure that is going to be performed on me, or on the person in charge of me, consists of. They have clarified my doubts about this and the possible risks and complications of the procedure. I am aware that the side effects of stitch removal are different for each person and may be related to the type of suture, suture material, location of the suture, type of material used, skill of the person performing and removing the stitches. , etc.

Some of the side effects are: Allergic reaction, opening of the wound, bleeding from the wound, inflammation of the wound, discomfort in or around the scar (itching, burning, sensitivity, etc.), infection if the recommended care is not performed. cleaning and disinfection

I give consent for the removal of stitches **Type_____ Located_____ Performed by_____ Specializing in_____ date** _____ at the **institution** _____ and I certify that I am requesting the removal of the stitches on the recommendation of the aforementioned doctor who orders it to be removed after _____days.

I also declare that I have full knowledge of what is stated in this document, I understand the commitments and responsibility that I assume and I accept them.

_____
Firma del paciente
I.D.

_____
Firma del Profesional
I.D.

_____
Firma Del acompañante o responsable
I.D.