Patient Informed Consent

- Please read the form.
- Ask about any part you do not understand.
- Be sure you have your questions answered before you sign this form.
- When you sign it, you are giving us permission to do the procedure described in this consent form.

I, _____ agree for provider _____,
(patient's name) *(name of provider performing the procedure)*

along with any assistants the provider may choose, to perform the following procedure on me:

_____.
(name of procedure - including left, right, or level)

Description of the procedure. Potential risks of the procedure. Purpose and intended outcomes of the procedure:

I understand and agree to each of the following:

- ☐ N/A **Anesthesia:** I may be given medicine to put me to sleep, make parts of my body numb, or help control pain. Providers with special training will give this medicine. These people may be an anesthesia provider, a nurse, or the doctor performing my procedure.
- **Other Treatment:** During the procedure, my provider may find sudden problems that need more care. My provider may need to do extra things to take care of me or evaluate me. My provider may do any additional or different treatment they determine necessary during the procedure to address these sudden problems. Even if not on this form.
- **Items taken out of my body:** The hospital may use or destroy anything taken out of my body during this procedure. "Use" means keeping for research or teaching. "Destroy" means safe disposal. I will not be paid for anything removed from my body.
- **Observer:** My provider may have someone watch my procedure. This may be a student, clinical peer, or supervisor.
- **Healthcare Team:** Other providers may help during this procedure. They will be identified by name in my medical record. These providers will only perform tasks within their scope of practice and clinical privileges at the hospital.
- ☐ N/A **Photos and Recordings:** Photos or video of my procedure may be taken. These photos and videos may be included in my medical record or used to teach other providers. If used for teaching, the hospital will remove any way to identify me from the photos and videos, such as my name and face. I will not be paid for any photos or videos.
- **Devices:** If necessary, I may have a device or implant put in my body. My Social Security number will be sent to the maker of the device. Federal law requires the hospital to give this information to the device maker. The device maker will use this information to reach me, if needed.
- ☐ N/A **Blood Transfusions:** Blood or blood products may be given to me if I need them during or after my procedure.
  - There are risks if I get blood or blood products. This may be a temporary reaction such as fever, chills, or skin rash. Other rare but more serious complications may occur such as an allergic reaction, shock, or death.
  - No promise can be given to me about the safety of the blood or blood products that I receive. Blood donors and blood products are carefully screened and tested to lessen the risk of transmitting any infectious disease. There is a rare change of getting an infection such as HIV or Hepatitis B or C.
- **Contact:** If a member of the healthcare team gets my blood or body fluids on them, I may need to have my blood tested. This is for the healthcare team member's safety. The results of my blood test will be shared with Occupational Health. The results are shared for the purpose of treating the healthcare team member.
- ☐ N/A **Narcotics**: I may be given strong pain medications (called narcotics) after my procedure. There are known risks to narcotics, including sleepiness or mental confusion, up to overdose and death. I understand I cannot drive or operate cars/machinery while taking narcotics. I understand they can end up in the hands of family and friends. I understand I can become dependent on them to feel normal even if I take them as my provider tells me to; I can develop an addiction that can cause cravings/withdrawals and possible overdose and death. I understand there are alternatives for narcotics to manage pain after my procedure. These can include nonsteroidal anti-inflammtory medications and acetaminophen.

Patient Name (Last, First, Middle)

DOD ID Number DOB: (DD-MMM-YYYY)

Blood or Blood Products Refusal ** *(only fill out this section if blood or blood products are refused)*

I **do not agree** to have blood or blood products given to me. The possible risks and damage to my health have been fully explained to me.

Signature: _____ **Date:** _____ **Time:** _____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Other (specify)** _____

I UNDERSTAND AND MY PROVIDER HAS TOLD ME:

- A description of the procedure I am having done. Why I need the procedure. The intended outcome.
- The risks and benefits to me of having this procedure done.
- What might happen to me if I refuse this procedure. The risks and benefits if I refuse this procedure.
- Other choices to having this procedure (if any), and associated risks and benefits.
- The risks and benefits if I choose a different treatment.
- Expected difficulties. Recovery time. How my pain will be treated.
- Restrictions while I am in the hospital and after I leave the hospital.
- There is no guarantee of the results of the procedure.
- I can change my mind before the procedure.
- I can refuse to have the procedure prior to its start.

I have had the chance to ask questions. I have had the chance to get more information about the procedure and its risks and benefits.

I give my consent for this procedure.

Signature: _____ **Date:** _____ **Time:** _____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Other (specify)** _____

Witness to Signature: _____

PROVIDER, PLEASE READ AND SIGN BELOW TO CERTIFY THE FOLLOWING:

1. Prior to the informed consent discussion, the patient or legal guardian was asked about their preferred language. Medical Interpreter was used: ☐ Yes ☐ No **If yes, name of interpreter or ID number: _____ If interpreter present, signature of interpreter: _____ If completed over the phone, name and signature of witness:_____
2. I have discussed the procedure described in this consent form with this patient/patient's legal guardian, including:
   - Description of the procedure, services, and medications to be provided. The purpose and intended outcome of the procedure.
   - Detailed information about the potential risks and complications. Expected difficulties. Benefits of the procedure. Problems that may occur during recuperation. Allowing the patient/patient's legal guardian to weigh the possible outcomes.
   - Other treatments or procedures available. The advantages and disadvantages of the other options available.
   - If the patient opts to refuse the procedure, the likely outcomes were explained.
   - The patient/patient's legal guardian has had the chance to ask questions and seek clarification on the proposed treatment and its effects. All questions were answered.

_____	_____	_____
Provider Printed Name	***Provider Signature***	***Date and Time***

Patient Name (Last, First, Middle)

DOD ID Number DOB: (DD-MMM-YYYY)