centura

Patient Label

INFORMED CONSENT FOR TREATMENT OR PROCEDURE

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Epic # 200089 Procedural/Treatment Consent

Facility Name: _____

Date of Procedure: _____

Interpreter Services or Other Communication Aids: *(check if applicable)*

☐ Would you prefer to speak to your provider through a translator or interpreter? Yes ☐ No ☐
☐ My preferred spoken or signed language is: _____
☐ If English is not my preferred language, an interpreter was provided to me. Interpreter # _____
☐ I declined an interpreter and requested a family member or friend to interpret.
Name of family or friend interpreter: _____
☐ I requested communication aids and they were provided (specify). _____

Reason for Procedure (medical condition):

_____
_____

Procedure: I approve and direct my healthcare provider _____ and assistants to perform this treatment or procedure:

_____
_____
_____

Anesthesia and Pain Control: My healthcare provider has told me about the medicines that will be used to manage my pain or make me sleepy for this procedure. He/ She has told me about the risks, benefits, and complications of anesthesia and pain control medicines.

Additional Procedures: My healthcare provider may find a new or different condition, or a new condition or problem might arise during the procedure. If he/she feels that other procedures are needed, I agree to these procedures. I understand that no guarantee can be made about the outcome of this procedure.

How the procedure may help me: My healthcare provider has explained the benefits of the procedure and I understand them.

How the procedure may harm me: I understand the risks of this procedure or treatment include:

_____
_____
_____
_____
_____

Some common risks include: Pain, infection, bleeding (which may require a transfusion), nerve injury (I might have numbness or lose strength or function of a body part), blood clots, injury to nearby structures, including perforation (poking a hole in some part of my body that was not intended), and reaction to a medication. The risks of the procedure can be serious, and there is a possibility of death.

Other choices if I don't have this procedure: I have been told of other reasonable treatment choices. I know the risks and possible benefits of these other choices. I have also been told of the risks and possible benefits of having no procedure or treatment for this condition.

Other people may be present: Some parts of the procedure may be completed by other members of the healthcare team. Team members may change during the procedure. Observers and other participants may be present for medical education or support.

Disposal of Tissue, Organs, or Body Parts: If any tissue, organs, or body parts are removed, after necessary testing, they will be disposed of with respect.

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Consent for Administration of Blood and Blood Products:

☐ Not necessary for this procedure.

I understand that I might need blood or blood products during or right after this procedure or treatment. My healthcare provider has explained risks, benefits, and alternatives to receiving blood or blood products. I understand there are risks to refuse blood or blood products.

☐ Yes, I want blood or blood products if my healthcare provider feels it is needed.

☐ No, I DO NOT want to receive blood or blood products.

CPR Advance Directives: If I have advance directives in place, I have talked with my healthcare provider about options for changing these directives during my procedure, and I have completed the required form.

Signatures

My signature below means that:

- I have read and understand this consent form.
- I have been given all the information I asked for about the procedure(s), risks, and other options.
- All my questions were answered.
- I agree to everything explained above.
- If I do not agree with any of the statements above, I have told my healthcare provider.
- I am free to withdraw my consent and not have this procedure.

Patient or Authorized Surrogate Healthcare Decision-Maker:

Signature: _____ Date: _____ Time: _____

Printed Name: _____

I have discussed the information above with the patient (or representative) and have answered their questions. It is my opinion that the person granting consent has fully understood all subjects discussed and consented to the procedure.

Licensed independent practitioner, or advanced practice provider who conducted the informed consent discussion:

Signature: _____ Date: _____ Time: _____

Printed Name: _____

Consent obtained via telephone (only when necessary)

Name of Authorized Surrogate Healthcare Decision-Maker: _____

Healthcare team member obtaining consent:

Signature: _____ Date: _____ Time: _____

Printed Name: _____

Signature: _____ Date: _____ Time: _____

Printed Name: _____