Directions for use
The consent forms included in this document are the ONLY approved consent forms in use at YKHC.

The Blank Consent Form (page 2) may only be used for significant invasive procedures for which a specific consent does not already exist.

Minor procedures such as Incision & Drainage outside the OR, toenail removal outside the OR, and joint aspiration, do not require use of consent forms.

Using this Acrobat Document
This is a hyperlinked Acrobat document. Make sure your cursor is in the shape of a hand (hand tool). Move the cursor to the title of the consent you want to choose at the right. When the hand changes to a pointing finger, click and your screen will jump to that form. Note the page number, choose your print command and enter the appropriate page(s) in the pages to print option area. For best results set the page scaling to “none." Print the desired number of copies.

To return to this page from any other page in the document, click the YKHC logo at the top of the page.

For further information about YKHC’s consent forms, please review the Policy included at the end of this document.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consent Form</td>
<td>2</td>
</tr>
<tr>
<td>Incision and Drainage of Abscess in the OR Consent</td>
<td>3</td>
</tr>
<tr>
<td>Bilateral Myringotomy with Tubes Consent</td>
<td>4</td>
</tr>
<tr>
<td>Cesearean Section Consent</td>
<td>5</td>
</tr>
<tr>
<td>Circumcision Consent</td>
<td>6</td>
</tr>
<tr>
<td>Colonoscopy Consent</td>
<td>7</td>
</tr>
<tr>
<td>Colposcopy Consent</td>
<td>8</td>
</tr>
<tr>
<td>Cystoscopy Consent</td>
<td>9</td>
</tr>
<tr>
<td>Dental Rehabilitation Consent</td>
<td>10</td>
</tr>
<tr>
<td>Dilation and Curettage Consent</td>
<td>11</td>
</tr>
<tr>
<td>Esophagastroduodenoscopy (EGD) Consent</td>
<td>12</td>
</tr>
<tr>
<td>Endometrial Biopsy Consent</td>
<td>13</td>
</tr>
<tr>
<td>Excisional Biopsy Consent</td>
<td>14</td>
</tr>
<tr>
<td>Exercise Stress Test Consent</td>
<td>15</td>
</tr>
<tr>
<td>External Cephalic Version Consent</td>
<td>16</td>
</tr>
<tr>
<td>Flexible Sigmoidoscopy Consent</td>
<td>17</td>
</tr>
<tr>
<td>Placement of IUD Consent</td>
<td>18</td>
</tr>
<tr>
<td>Loop Electrical Excision Procedure Consent</td>
<td>19</td>
</tr>
<tr>
<td>Lumbar Puncture Consent</td>
<td>20</td>
</tr>
<tr>
<td>Mesiodens Consent</td>
<td>21</td>
</tr>
<tr>
<td>Moderate / Procedural Sedation Consent</td>
<td>22</td>
</tr>
<tr>
<td>Laparoscopic Tubal Ligation Consent</td>
<td>23</td>
</tr>
<tr>
<td>Mini-Lap Tubal Ligation Consent</td>
<td>24</td>
</tr>
<tr>
<td>Post Partub Tubal Ligation Consent</td>
<td>25</td>
</tr>
<tr>
<td>Thoracentesis Consent</td>
<td>26</td>
</tr>
<tr>
<td>Blood Transfusion Consent</td>
<td>27</td>
</tr>
<tr>
<td>IVP (Excretory Urogram) Consent</td>
<td>28</td>
</tr>
<tr>
<td>Outpatient Oral Surgery Consent</td>
<td>29</td>
</tr>
<tr>
<td>Implanon Consent Form</td>
<td>30</td>
</tr>
<tr>
<td>Implanon Removal Consent</td>
<td>31</td>
</tr>
<tr>
<td>Anesthesia Consent</td>
<td>32</td>
</tr>
<tr>
<td>Diagnostic Hysteroscopy Consent</td>
<td>33</td>
</tr>
<tr>
<td>OB Nitrous Oxide Consent</td>
<td>34</td>
</tr>
<tr>
<td>Vasectomy Consent</td>
<td>35</td>
</tr>
<tr>
<td>Permanent Birth Control (“Essure”) Consent</td>
<td>37</td>
</tr>
<tr>
<td>Permanent Birth Control (“Essure”) Consent</td>
<td>38</td>
</tr>
<tr>
<td>Consent for Contrast Media</td>
<td>39</td>
</tr>
<tr>
<td>Consent for Birth After Cesarean Section</td>
<td>40</td>
</tr>
<tr>
<td>POLICY: Patient Consent for Treatment</td>
<td>41</td>
</tr>
</tbody>
</table>
PROCEDURE CONSENT

I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
</thead>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

__________________________

__________________________

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent or Guardian Signature</th>
<th>Date and Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Person Obtaining Consent</th>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Translator used: [ ] Yes [ ] No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Translator Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Translator Printed Name</th>
</tr>
</thead>
</table>

PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DOB: ___________ Med Rec #: ______</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DOS: ___________ Encounter: ______</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Residence: ______________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Facility: ________________________</th>
</tr>
</thead>
</table>

Frm#: YK00142_v5.p2  Rev. Date 10-01-19
PROCEDURE CONSENT
I hereby authorize __________________________ and such assistants as he/she may designate, to perform the following operation or procedure: __________________________

Technical Description
• Incision and Drainage of Abscess in the OR

Lay Description
• Cut open and drain the pus out of the boil in the OR

_____________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Open infected area so it can drain and heal</td>
<td>• Pain</td>
<td>• Worsening of infection</td>
<td>• Hot packs and antibiotics</td>
</tr>
<tr>
<td></td>
<td>• bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• possible worsening of infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• scar formation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Translator used: [ ] Yes [ ] No

_____________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
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<th>Risks of not having the procedure</th>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• possible worsening of infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• scar formation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

_____________________________

_____________________________

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
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<td>Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

_____________________________

_____________________________

Translator used: [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Translator Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>
PROCEDURE CONSENT

I hereby authorize ____________________________, and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description
- Right □  Left □  Bilateral □  Myringotomy with Insertion of Vented Tubes

Lay Description
- Insert Tubes into the ears

__________________________________________ has discussed with me the information briefly summarized below:

Purpose
- To drain fluid from the ears to prevent ear infections and hearing loss.

Potential Risks
(not necessarily all of them)
- Bleeding, Infection

Risks of not having the procedure
- Unresolved hearing loss / Draining ears

Alternative Treatments

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: □ Yes  □ No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ____________________________ Date & Time ____________________________

Parent or Guardian Signature ____________________________ Date & Time ____________________________

Printed Name

Signature of Person Obtaining Consent ____________________________ Date & Time ____________________________

Printed Name

Witness Signature ____________________________ Date & Time ____________________________

Printed Name

Translator used: □ Yes  □ No

Translator Signature ____________________________ Date & Time ____________________________

Translator Printed Name

PATIENT INFORMATION

Name: __________________________________________

DOB: ____________ Med Rec #: ____________

DOS: ____________ Encounter: ____________

Residence: __________________________________________

Facility: __________________________________________
I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Translator used: Yes No</td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

**PROCEDURE CONSENT**

I hereby authorize and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Primary</th>
<th>Repeat</th>
<th>Cesarean Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>Make an incision in the abdomen and womb to allow surgical delivery of the baby</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

__________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To maximize the safety of the delivery for the baby and the mother.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>Pain</td>
</tr>
<tr>
<td></td>
<td>Bleeding possibly requiring a blood transfusion</td>
</tr>
<tr>
<td></td>
<td>Infection</td>
</tr>
<tr>
<td></td>
<td>Perforation of an internal organ which may require transfer to Anchorage for surgery</td>
</tr>
<tr>
<td></td>
<td>Cesarean Hysterectomy</td>
</tr>
<tr>
<td></td>
<td>A laceration to the baby</td>
</tr>
<tr>
<td></td>
<td>In very rare cases death to the baby or mother.</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>Increased risk of fetal injury or death. (If you had a previous C-Section, there is an increased risk of uterine rupture with vaginal delivery.)</td>
</tr>
<tr>
<td>Alternative Treatments</td>
<td></td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: Yes No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

__________________________________________________________________________

__________________________________________________________________________

**PATIENT INFORMATION**

Name: ____________________________________________
DOB: _____________ Med Rec #: ________________
DOS: _____________ Encounter: ________________
Residence: _______________________________________
Facility: ________________________________________
PROCEDURE CONSENT

I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Circumcision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Removal of the tip of the skin covering the penis</td>
</tr>
</tbody>
</table>

_______________________________
____________________________
Patient Signature  Date & Time

_______________________________
____________________________
Parent or Guardian Signature Date and Time

_____________________________________________
_____________________________________________
Printed Name

_______________________________
____________________________
Signature of Person Obtaining Consent  Date & Time

_______________________________
____________________________
Translator Signature Date & Time

_____________________________________________
_____________________________________________
Translator Printed Name

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

________________________________________________________________

________________________________________________________________

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  Yes  No

I consent to the procedure/operation and sign this of my own free will.

_______________________________  _________________________
Patient Signature                  Date & Time

_______________________________  _________________________
Parent or Guardian Signature       Date and Time

_______________________________
Printed Name

_______________________________  _________________________
Signature of Person Obtaining Consent  Date & Time

_______________________________
Printed Name

_______________________________  _________________________
Witness Signature                  Date & Time

_______________________________
Printed Name

_____________________________________________
Translator used:  Yes  No

_______________________________  _________________________
Translator Signature              Date & Time

_______________________________
Translator Printed Name

PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>Med Rec #: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB: __________________</td>
<td>Encounter: ____________________________</td>
</tr>
<tr>
<td>DOS: __________________</td>
<td>Residence: ____________________________</td>
</tr>
<tr>
<td>Facility: __________________</td>
<td></td>
</tr>
</tbody>
</table>

Frm#: YK00142_v5.p6  Rev. Date 10-01-19
PROCEDURE CONSENT

I hereby authorize _____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Colonoscopy with possible biopsy or polyp removal</td>
<td>• Look in the large intestine with a flexible camera and possibly take pieces of tissue and remove growths.</td>
</tr>
<tr>
<td>• Procedural sedation</td>
<td>• Give medications to make you sleepy and more comfortable during the procedure.</td>
</tr>
<tr>
<td>• Picture taking for medical documentation</td>
<td></td>
</tr>
</tbody>
</table>

________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To examine your large intestine for cancer, polyps (growths), bleeding, and infection.</td>
<td>• Drug reaction including allergic reaction, low blood pressure, difficulty breathing, and death.</td>
</tr>
<tr>
<td></td>
<td>• Bleeding which can occur immediately or even weeks after the procedure.</td>
</tr>
<tr>
<td></td>
<td>• Perforation (causing a hole in the intestine) which can occur immediately or be delayed.</td>
</tr>
<tr>
<td></td>
<td>• Missing a polyp or cancer.</td>
</tr>
<tr>
<td></td>
<td>• Inability to complete the procedure requiring additional testing (such as a barium enema).</td>
</tr>
<tr>
<td></td>
<td>• If a complication occurs, you might need a blood transfusion, you might need to be hospitalized or medevacced to Anchorage for surgery, and you could possibly die.</td>
</tr>
</tbody>
</table>

Risks of not having the procedure
• Undetected polyps or cancer resulting in delayed treatment

Alternative Treatments
• Barium enema (an X-ray of the large intestine)
• No sedation

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
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</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

Translator used: [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Translator Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator Printed Name</td>
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<tr>
<th>Name:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>DOS:</td>
<td>Encounter:</td>
<td></td>
</tr>
<tr>
<td>Residence:</td>
<td>Facility:</td>
<td></td>
</tr>
</tbody>
</table>

Frm#: YK00142_v5.p7  Rev. Date 10-01-19
I consent to the procedure/operation and sign this of my own free will.

Patient Signature ___________________________ Date & Time ___________________________

Parent or Guardian Signature ___________________________ Date and Time ___________________________

Printed Name ___________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ___________________________

Printed Name ___________________________

Witness Signature ___________________________ Date & Time ___________________________

Printed Name ___________________________

Translator used: Yes ☐ No ☐

Translator Signature ___________________________ Date & Time ___________________________

Translator Printed Name ___________________________

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: Yes ☐ No ☐

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

__________________________ has discussed with me the information briefly summarized below:

Purpose • Looking at the cervix with a magnifying lens and taking a small piece or scraping of any abnormal tissue for further examination looking precancer or cancer

Potential Risks (not necessarily all of them) • Bleeding, Infection • Missing an abnormal area that exists. • Vaginal discharge.

Risks of not having the procedure • Failure to diagnose a pre-cancer or cancer that requires treatment.

Alternative Treatments • Observation without treatment

PROCEDURE CONSENT
I hereby authorize ___________________________
and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description • Colposcopy with Cervical Biopsy and Endocervical Curetteage

Lay Description • Looking for abnormal cells on the opening of my cervix or womb that could turn into precancer or cancer

__________________________ has discussed with me the information briefly summarized below:

Purpose • Looking at the cervix with a magnifying lens and taking a small piece or scraping of any abnormal tissue for further examination looking precancer or cancer

Potential Risks (not necessarily all of them) • Bleeding, Infection • Missing an abnormal area that exists. • Vaginal discharge.

Risks of not having the procedure • Failure to diagnose a pre-cancer or cancer that requires treatment.

Alternative Treatments • Observation without treatment

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ___________________________ Date & Time ___________________________

Parent or Guardian Signature ___________________________ Date and Time ___________________________

Printed Name ___________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ___________________________

Printed Name ___________________________

Witness Signature ___________________________ Date & Time ___________________________

Printed Name ___________________________

Translator used: Yes ☐ No ☐

Translator Signature ___________________________ Date & Time ___________________________

Translator Printed Name ___________________________
**PROCEDURE CONSENT**

I hereby authorize ___________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>□  Flexible</th>
<th>□  Rigid</th>
<th>Cystoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>▪  Look into the bladder with a lighted scope</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>▪  Rule out bladder tumors or obstruction to urinary flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>▪  Bleeding and infection</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td></td>
</tr>
<tr>
<td>Alternative Treatments</td>
<td>▪  Do nothing</td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>__________________________</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>__________________________</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td>__________________________</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>__________________________</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td>__________________________</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>__________________________</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td>__________________________</td>
<td></td>
</tr>
<tr>
<td>Translator used:  □  Yes  □  No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>__________________________</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td>__________________________</td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT INFORMATION**

Name: __________________________
DOB: ________________ Med Rec #: ________________
DOS: ________________ Encounter: __________________________
Residence: __________________________
Facility: __________________________
**PROCEDURE CONSENT**

I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Complete Dental Rehabilitation in the Operating Room under General Anesthesia</td>
<td>• Dental treatment while the patient is asleep, including, but not limited to: dental exam, dental x-rays, extractions, biopsies, tooth-colored and silver fillings, tooth nerve treatments, silver crowns, sealants, cleaning and fluoride, photos for medical documentation.</td>
</tr>
<tr>
<td>• Operative and surgical repair of all dental lesions and disease including, but not limited to: head and neck exam, dental x-rays, extraction(s) of erupted and unerupted teeth, biopsies, removal of tooth decay, dental restorations, endodontic treatments, dental sealants, dental prophylaxis, fluoride application, local anesthesia, photographs for medical documentation.</td>
<td></td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: ☐ Yes ☐ No

If patient is incompetent or a minor, complete the following:

*Patient is unable to give consent because:*

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allergic reaction</td>
<td>• To improve the oral health of the patient.</td>
</tr>
<tr>
<td>• Swelling, pain, infection, fever, vomiting</td>
<td></td>
</tr>
<tr>
<td>• Damage to developing permanent teeth especially when extracting unerupted teeth</td>
<td></td>
</tr>
<tr>
<td>• Dental space loss.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Progression of the existing dental disease and/or infection</td>
<td>• Two or more difficult dental appointments with or without restraints and/or light sedation.</td>
</tr>
<tr>
<td>• Infection, pain, swelling, fever</td>
<td></td>
</tr>
<tr>
<td>• Difficulty eating and/or sleeping</td>
<td></td>
</tr>
<tr>
<td>• Damage or disruption of developing permanent teeth.</td>
<td></td>
</tr>
</tbody>
</table>

I consent to the procedure/operation and sign this of my own free will.

- Patient Signature ____________________________ Date & Time
- Parent or Guardian Signature ____________________________ Date and Time
- Printed Name ____________________________
- Signature of Person Obtaining Consent ____________________________ Date & Time
- Printed Name ____________________________
- Witness Signature ____________________________ Date & Time
- Printed Name ____________________________
- Translator used: ☐ Yes ☐ No
- Translator Signature ____________________________ Date & Time
- Translator Printed Name ____________________________

**PATIENT INFORMATION**

Name: ____________________________
DOB: _____________ Med Rec #: _____________
DOS: _____________ Encounter: _____________
Residence: ____________________________
Facility: ____________________________

Frm#: YK00142_v5.p10  Rev. Date 10-01-19
PROCEDURE CONSENT

I hereby authorize _____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

**Technical Description**
- Dilation and Curettage

**Lay Description**
- Dilate cervix and empty contents of uterus with suction and scraping out uterus

_________________________ has discussed with me the information briefly summarized below:

**Purpose**
- Remove non-living pregnancy to prevent infection and bleeding

**Potential Risks**
- Infection
- Heavy bleeding requiring blood transfusion
- Perforate uterus

**Risks of not having the procedure**
- Infection, Bleeding

**Alternative Treatments**
- Waiting for uterus to pass pregnancy on its own

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  [ ] Yes  [ ] No

If patient is incompetent or a minor, complete the following:

*Patient is unable to give consent because:*

________________________________________________________________________

________________________________________________________________________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature _____________________________ Date & Time _____________________________

Parent or Guardian Signature _____________________________ Date and Time _____________________________

Printed Name ________________________________________

Signature of Person Obtaining Consent _____________________________ Date & Time _____________________________

Printed Name ________________________________________

Witness Signature _____________________________ Date & Time _____________________________

Printed Name ________________________________________

Translator used:  [ ] Yes  [ ] No

Translator Signature _____________________________ Date & Time _____________________________

Translator Printed Name ________________________________________

PATIENT INFORMATION

Name: ________________________________________

DOB: ________________ Med Rec #: ________________

DOS: ________________ Encounter: _____________________________

Residence: ________________________________________

Facility: ________________________________________
I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent. I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Stomach biopsies may be taken to aid Alaska CDC Surveillance of Helicobacter pylori and its resistance to antibiotics. This may allow more effective treatment for YKHC patients. To opt out of this surveillance, initial here:__________

Clinical students may observe:  

Yes  
No

If patient is incompetent or a minor, complete the following:  
Patient is unable to give consent because:  

__________________________  

__________________________  

__________________________  

__________________________  

__________________________  

__________________________  

PATIENT INFORMATION  

Name: ____________________________  
DOB: ___________  Med Rec #: ___________  
DOS: ___________  Encounter: ___________  
Residence: ____________________________  
Facility: ____________________________  

Translator used:  

Yes  
No

Translator Signature  Date & Time  

Translator Printed Name  

I consent to the procedure/operation and sign this of my own free will.  

________________________________________  
Patient Signature  Date & Time

________________________________________  
Parent or Guardian Signature  Date and Time

________________________________________  
Printed Name

________________________________________  
Signature of Person Obtaining Consent  Date & Time

________________________________________  
Printed Name

________________________________________  
Witness Signature  Date & Time

________________________________________  
Printed Name

________________________________________  
Translator Signature  Date & Time

________________________________________  
Translator Printed Name

Frm#: YK00142_v5.p12  Rev. Date 10-01-19
I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
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<th>Patient Signature</th>
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<tbody>
<tr>
<td>Parent or Guardian Signature</td>
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<tr>
<td>Printed Name</td>
<td></td>
</tr>
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<td>Printed Name</td>
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</tr>
<tr>
<td>Translator used:</td>
<td></td>
</tr>
<tr>
<td>Yes  No</td>
<td></td>
</tr>
<tr>
<td>printed Name</td>
<td></td>
</tr>
<tr>
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<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Clinical students may observe:</td>
<td></td>
</tr>
<tr>
<td>Yes  No</td>
<td></td>
</tr>
</tbody>
</table>

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

____________________________________________________________________

____________________________________________________________________

PATIENT INFORMATION

Name: ____________________________
DOB: ________________ Med Rec #: ________________
DOS: ________________ Encounter: ________________
Residence: ____________________________
Facility: ____________________________

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

I consent to the procedure/operation and sign this of my own free will.

| Translator used: |             |
| Yes  No |             |
| Printed Name |             |

I hereby authorize __________________________________________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description
• Endometrial Biopsy

Lay Description
• Put a small tube in my uterus or womb to scrape or suction the lining

__________________________ has discussed with me the information briefly summarized below:

Purpose
• To collect uterine tissue to help determine the cause of my irregular bleeding.

Potential Risks
(Not necessarily all of them)
• Discomfort, bleeding, infection
• Injury to the womb
• Potentially missing an abnormal site.

Risks of not having the procedure
• Missing cancer or precancerous abnormalities of the endometrium

Alternative Treatments
• Observation without treatment
• Dilatation & Curettage.

Endometrial Biopsy Consent
PROCEDURE CONSENT
I hereby authorize __________________________
and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excisional Biopsy</td>
<td>To remove a skin abnormality and/or part of a skin abnormality</td>
</tr>
</tbody>
</table>

_______________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
<th>Risks of not having the procedure</th>
</tr>
</thead>
</table>
| To remove abnormal growths and/or test tissue for diagnostic purposes | • Infection, scarring,  
• Failure to remove lesion entirely, and re-growth of lesion  
• Reaction to local anesthetic  
• Need for wider excision. | • Undiagnosed cancer or other tissue abnormalities. |

Alternative Treatments • No Biopsy and observation.

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  Yes  No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Translator used:  Yes  No</td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

PATIENT INFORMATION

| Name: | |
| DOB: | Med Rec #: |
| DOS: | Encounter: |
| Residence: | |
| Facility: | |
PROCEDURE CONSENT
I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description • Exercise Stress Test

Lay Description • To monitor and to evaluate the ability of your heart to respond to exercise.

__________________________ has discussed with me the information briefly summarized below:

Purpose • To evaluate the ability of your heart to respond to exercise.

Potential Risks (not necessarily all of them) • In rare cases, such symptoms as abnormal heart rhythms, fainting, heart attacks, and in extremely rare cases, death.

Risks of not having the procedure • Undiagnosed heart disease with increased risk of death.

Alternative Treatments

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  [ ] Yes  [ ] No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:
________________________________________________________________________
________________________________________________________________________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ____________________________ Date & Time ____________________________

Parent or Guardian Signature ____________________________ Date and Time ____________________________

Printed Name ____________________________

Signature of Person Obtaining Consent ____________________________ Date & Time ____________________________

Printed Name ____________________________

Witness Signature ____________________________ Date & Time ____________________________

Printed Name ____________________________

Translator used:  [ ] Yes  [ ] No

Translator Signature ____________________________ Date & Time ____________________________

Translator Printed Name ____________________________

PATIENT INFORMATION
Name: ____________________________
DOB: ____________________________ Med Rec #: ____________________________
DOS: ____________________________ Encounter: ____________________________
Residence: ____________________________
Facility: ____________________________
PROCEDURE CONSENT

I hereby authorize ___________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description  •  External Cephalic Version

Lay Description  •  Attempt to turn the baby until its head is down by pushing on your abdomen.

__________________________________________ has discussed with me the information briefly summarized below:

Purpose  •  To move the baby into a position which allows a safe vaginal delivery.

Potential Risks
(Not necessarily all of them)
• Changes in the baby’s heart rate which resolve shortly after finishing the procedure
• Rupture of the bag of waters and starting labor.
• Very rarely, severe changes in the baby’s heart rate and/or separation of the placenta from the uterus, necessitating an emergency cesarean section.

Risks of not having the procedure
• Cesarean section is the recommended route of delivery for babies that are breech, to prevent serious complications of vaginal delivery such as spinal cord injury.

Alternative Treatments
• Elective cesarean section
• Breech vaginal delivery

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  ☐ Yes  ☐ No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

__________________________________________

__________________________________________

PATIENT INFORMATION

Name: ____________________________
DOB: __________   Med Rec #: __________
DOS: __________   Encounter: __________
Residence: ____________________________
Facility: ____________________________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ____________________________  Date & Time

Parent or Guardian Signature ____________________________  Date & Time

Printed Name ____________________________

Signature of Person Obtaining Consent ____________________________  Date & Time

Printed Name ____________________________

Witness Signature ____________________________  Date & Time

Printed Name ____________________________

Translator used:  ☐ Yes  ☐ No

Translator Signature ____________________________  Date & Time

Translator Printed Name ____________________________
PROCEDURE CONSENT

I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description
- Flexible Sigmoidoscopy with Biopsy with Conscious Sedation
- Take pictures for medical documentation

Lay Description
- Look into rectum and large intestine with a telescope to look for bleeding and cancer
- Take pieces of tissue if they look suspicious.
- Give you medicine to make you sleepy.

__________________________________________
Printed Name

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: ☐ Yes ☐ No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

__________________________________________
__________________________________________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ____________________________ Date & Time ____________________________

Parent or Guardian Signature ____________________________ Date and Time ____________________________

Printed Name

Signature of Person Obtaining Consent ____________________________ Date & Time ____________________________

Printed Name

Witness Signature ____________________________ Date & Time ____________________________

Printed Name

Translator used: ☐ Yes ☐ No

Translator Signature ____________________________ Date & Time ____________________________

Translator Printed Name

PATIENT INFORMATION

Name: __________________________________________
DOB: _______________ Med Rec #: _______________
DOS: _______________ Encounter: _______________
Residence: ______________________________________
Facility: _______________________________________

Frm#: YK00142_v5.p17  Rev. Date 10-01-19
PROCEDURE CONSENT

I hereby authorize _____________________________
and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Placement of IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Put IUD in uterus to prevent pregnancy</td>
</tr>
</tbody>
</table>

________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• Prevent pregnancy</th>
</tr>
</thead>
</table>
| Potential Risks (not necessarily all of them) | • Risk of serious pelvic infection resulting in infertility and/or future risk of ectopic pregnancy.  
• Risk of painful periods and spotting between periods.  
• Risk of uterine perforation. 
• Risk of IUD coming out.  
• Risk of undesired pregnancy. |
| Risks of not having the procedure | • Undesired Pregnancy |
| Alternative Treatments | • All other forms of birth control. |

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

________________________

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

Translator used: [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Translator Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

PATIENT INFORMATION

Name: ____________________________
DOB: ___________ Med Rec #: ___________
DOS: ___________ Encounter: ____________________
Residence: ____________________________
Facility: ____________________________

Frm#: YK00142_v5.p18  Rev. Date 10-01-19
I consent to the procedure/operation and sign this of my own free will.

Patient Signature ___________________________ Date & Time ___________________________

Parent or Guardian Signature ___________________________ Date and Time ___________________________

Printed Name ___________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ___________________________

Printed Name ___________________________

Witness Signature ___________________________ Date & Time ___________________________

Printed Name ___________________________

Translator used: Yes ☐ No ☐

Translator Signature ___________________________ Date & Time ___________________________

Translator Printed Name ___________________________

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

PATIENT INFORMATION

Name: ___________________________

DOB: ___________ Med Rec #: ___________

DOS: ___________ Encounter: ___________

Residence: ___________________________

Facility: ___________________________
I consent to the procedure/operation and sign this of my own free will.

I hereby authorize ________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

**Technical Description**
- Lumbar Puncture (Spinal Tap)

**Lay Description**
- Placing a needle in the back to collect fluid that surrounds the spinal cord

______________________________ has discussed with me the information briefly summarized below:

**Purpose**
- To evaluate for infection or bleeding of the meninges, brain, and/or spinal cord

**Potential Risks**
- Bleeding, infection, bruising
- Sensory motor damage of the lower extremities which include: numbness, weakness, paralysis
- These sensory motor changes are rare and usually temporary.

**Risks of not having the procedure**
- Undiagnosed infection of the Meninges, brain and/or spinal cord resulting in brain damage or death

**Alternative Treatments**
- Treatment for presumed infection of the meninges, brain, and/or spinal cord which includes in hospital IV antibiotics.

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes  [ ] No

If patient is incompetent or a minor, complete the following: *Patient is unable to give consent because:*

______________________________

______________________________

**PATIENT INFORMATION**

Name: __________________________________________
DOB: __________________ Med Rec #: ____________
DOS: __________________ Encounter: ____________
Residence: _____________________________________
Facility: _______________________________________

Translator used: [ ] Yes  [ ] No

Printed Name

Signature of Person Obtaining Consent __________________ Date & Time

Printed Name

Witness Signature __________________ Date & Time

Printed Name

Translator Signature __________________ Date & Time

Translator Printed Name
PROCEDURE CONSENT

I hereby authorize ___________________________
and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description
• Mesiodens or supernumerary tooth extraction(s).

Lay Description
• Surgical removal of extra teeth in the upper or lower jaw.

__________________________ has discussed with me the information briefly summarized below:

Purpose
• To remove extra teeth.

Potential Risks
(Not necessarily all of them)
• Allergic reaction, swelling, pain, infection, fever, vomiting
• Damage or disruption of surrounding developing permanent teeth

Risks of not having the procedure
• Damage or disruption of surrounding developing permanent teeth
• Eruption of teeth into the nasal sinuses
• Formation of cysts or tumors
• Poor alignment of permanent teeth
• Impaction of permanent teeth
• Eruption of extra teeth into the oral cavity
• Interference with speech and other oral functions
• Increased difficulty of surgery if you wait until a later date.

Alternative Treatments
• No treatment
• Extraction
• Postponing extraction until the surrounding permanent teeth have finished the formation of their roots
• Radiographic monitoring at least every 5 years if extra teeth not removed.

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: □ Yes □ No

I consent to the procedure/operation and sign this of my own free will.

_______________________________  ______________________________
Patient Signature  Date & Time

_______________________________  ______________________________
Parent or Guardian Signature  Date & Time

_______________________________
Printed Name

_______________________________  ______________________________
Signature of Person Obtaining Consent  Date & Time

_______________________________
Printed Name

_______________________________  ______________________________
Witness Signature  Date & Time

_______________________________
Printed Name

Translator used: □ Yes □ No

_______________________________  ______________________________
Translator Signature  Date & Time

_______________________________
Translator Printed Name

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

_______________________________

PATIENT INFORMATION

Name: __________________________
DOB: ___________________ Med Rec #: ________________
DOS: ___________________ Encounter: ________________
Residence: __________________________
Facility: __________________________

Frm#: YK00142_v5.p21  Rev. Date 10-01-19
PROCEDURE CONSENT

I hereby authorize __________________________
and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description  • Moderate / Procedural Sedation in the operating room if necessary

Lay Description  • Give you medicine to make you sleepy and/or put you to sleep and help you breath in the operating room if necessary.

__________________________ has discussed with me the information briefly summarized below:

Purpose  • To minimize patient's anxiety and pain to allow performance of a procedure

Potential Risks
(not necessarily all of them)
• Possible drug reaction
• Respiratory arrest possibly requiring intubation
• Hypotension
• Pneumonia
• Failure of sedation
• In extreme rare cases death

Risks of not having the procedure

Alternative Treatments  • No Sedation or General Anesthesia

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes  [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

____________________________________________________

____________________________________________________

I consent to the procedure/operation and sign this of my own free will.

_____________________________  __________________________
Patient Signature  Date & Time

_____________________________  __________________________
Parent or Guardian Signature  Date and Time

_____________________________
Printed Name

_____________________________
Signature of Person Obtaining Consent  Date & Time

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Printed Name

_____________________________
Witness Signature  Date & Time

_____________________________
Printed Name

Translator used: [ ] Yes  [ ] No

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Translator Signature  Date & Time

_____________________________
Translator Printed Name

PATIENT INFORMATION

Name: __________________________
DOB: __________ Med Rec #: __________
DOS: __________ Encounter: __________
Residence: __________________________
Facility: __________________________
PROCEDURE CONSENT
I hereby authorize ___________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Laparoscopic Tubal Ligation</td>
<td>• Do surgery to destroy Fallopian tubes to prevent future pregnancy, using a small fiberoptic scope or through a larger abdominal incision if necessary.</td>
</tr>
<tr>
<td>• Possible open Tubal Ligation and taking pictures for medical documentation.</td>
<td>• Taking pictures of the procedure for medical documentation.</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prevent future pregnancy</td>
<td>• Damage to intestines or bladder</td>
<td>• Pregnancy and all of its inherent risk</td>
<td>• All other birth control methods, including vasectomy for partner.</td>
</tr>
<tr>
<td></td>
<td>• Severe bleeding requiring blood transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Infection in the wound requiring antibiotics and/or hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Scarring and small risk of an ectopic if pregnant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Small risk of future pregnancy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

__________________________

__________________________

I consent to the procedure/operation and sign this of my own free will.

__________________________ Date & Time
Patient Signature

__________________________ Date and Time
Parent or Guardian Signature

__________________________
Printed Name

__________________________ Date & Time
Signature of Person Obtaining Consent

__________________________
Printed Name

__________________________ Date & Time
Witness Signature

__________________________
Printed Name

__________________________
Translator Signature

__________________________
Translator Printed Name

PATIENT INFORMATION

Name: ____________________________________________
DOB: __________________ Med Rec #: __________________
DOS: __________________ Encounter: __________________
Residence: _______________________________________
Facility: _________________________________________
PROCEDURE CONSENT

I hereby authorize ______________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Mini-Lap Tubal Ligation</th>
</tr>
</thead>
</table>
| Lay Description        | • An incision is made in the lower abdomen to allow access to your tubes.  
|                        | • A piece will be removed from each tube to prevent future pregnancy. |

______________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• To prevent future pregnancy</th>
</tr>
</thead>
</table>
| Potential Risks (not necessarily all of them) | • Bleeding, infection  
| | • Injury to internal organs  
| | • Removal of round ligament nad not tube  
| | • 1 in 300 risk of pregnancy in future with risk of ectopic if pregnant  
| | • Death |
| Risks of not having the procedure | • Pregnancy & all of its inherent risk |
| Alternative Treatments | • All other forms of birth control including vasectomy of partner, norplant, depo provera, IUD, oral birth control pills, diaphragm, condoms & foam, sponge, rhythm, and abstinence. |

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes  [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

I consent to the procedure/operation and sign this of my own free will.

______________________

Patient Signature              Date & Time

______________________

Parent or Guardian Signature   Date and Time

______________________

Printed Name

______________________

Signature of Person Obtaining Consent Date & Time

______________________

Printed Name

______________________

Witness Signature Date & Time

______________________

Translator used: [ ] Yes  [ ] No

______________________

Translator Signature Date & Time

______________________

Translator Printed Name

______________________

Patient Information

Name: ______________________

DOB: ___________ Med Rec #: ___________

DOS: ___________ Encounter: ___________

Residence: ______________________

Facility: ______________________
I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Post Partum Tubal Ligation</th>
</tr>
</thead>
</table>
| Lay Description       | • An incision is made beneath the belly button to allow access to your tubes.  
|                       | • A piece will be removed from each tube to prevent future pregnancy. |

__________________________ has discussed with me the information briefly summarized below:

**Purpose**
- To prevent future pregnancy.

**Potential Risks** (not necessarily all of them)
- Bleeding, infection
- Injury to internal organs
- Removal of round ligament & not tube
- in 300 risk of pregnancy in future with risk of ectopic if pregnant

**Risks of not having the procedure**
- Pregnancy & all of its inherent risk

**Alternative Treatments**
- All other forms of birth control including vasectomy of partner, norplant, depo provera, IUD, oral birth control pills, diaphragm, condoms and foam, sponge, rhythm, and abstinence.

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  
- [ ] Yes  
- [ ] No

If patient is incompetent or a minor, complete the following:

**Patient is unable to give consent because:**

__________________________

__________________________

**I consent to the procedure/operation and sign this of my own free will.**

<table>
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<th>Patient Signature</th>
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<td>Parent or Guardian Signature</td>
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<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
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<tr>
<td>Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

Translator used:  
- [ ] Yes  
- [ ] No

<table>
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<th>Translator Signature</th>
<th>Date &amp; Time</th>
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<tr>
<td>Residence:</td>
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<tr>
<td>Facility:</td>
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</tbody>
</table>

Facility: ____________________________
**PROCEDURE CONSENT**

I hereby authorize ___________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thoracentesis</td>
<td>• Draining lung fluid</td>
</tr>
</tbody>
</table>

________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• To drain fluid and air from around lungs</td>
<td>• To allow you to breathe better and help diagnose the cause of the problem.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
<th>Risk of not having the procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bleeding, infection</td>
<td>• Worsening or no improvement in breathing</td>
</tr>
<tr>
<td>• Collapsed lung</td>
<td>• Risk of breathing problems worsening and progressing to suffocation.</td>
</tr>
<tr>
<td>• Need for chest tube.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not draining fluid and use of pain management and oxygen only.</td>
<td></td>
</tr>
</tbody>
</table>

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I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following: **Patient is unable to give consent because:**

I consent to the procedure/operation and sign this of my own free will.

<table>
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<tr>
<th>Patient Signature</th>
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<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
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</table>

Printed Name

Signature of Person Obtaining Consent

Date & Time

Printed Name

Witness Signature

Date & Time

Printed Name

Translator used: [ ] Yes [ ] No

Translator Signature

Date & Time

Translator Printed Name

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**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Name:</th>
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<tbody>
<tr>
<td>DOB:</td>
<td></td>
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<td>DOS:</td>
<td>Encounter:</td>
</tr>
<tr>
<td>Residence:</td>
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<tr>
<td>Facility:</td>
<td></td>
</tr>
</tbody>
</table>

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Frm#: YK00142_v5.p26  Rev. Date 10-01-19
PROCEDURE CONSENT
I hereby authorize ________________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Blood Transfusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Blood Transfusion</td>
</tr>
</tbody>
</table>

_______________________________ has discussed with me the information briefly summarized below:

| Purpose | • Increasing oxygen in blood needed to support body functions  
|---------------------|--------------------------------------------------|
| Potential Risks (not necessarily all of them) | • Viral Infection,  
| | • Hepatitis B  
| | • Fever, rash  
| | • Hemolytic Reaction  
| | • Shortness of breath  
| | • Hives  
| | • Acquired Immune Deficiency Syndrome (AIDS) |

Risks of not having the procedure

Alternative Treatments

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

________________________________________________________________________________________________________

________________________________________________________________________________________________________

I consent to the procedure/operation and sign this of my own free will.

<table>
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<td>Translator used: [ ] Yes [ ] No</td>
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PATIENT INFORMATION

Name: __________________________________________
DOB: __________________ Med Rec #: __________________
DOS: __________________ Encounter: __________________
Residence: __________________________________________
Facility: __________________________________________

Translator used: [ ] Yes [ ] No

Translator Signature                                                                                     | Date & Time |
Translator Printed Name                                                                               |             |
**PROCEDURE CONSENT**

I hereby authorize __________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVP (Excretory Urogram)</td>
<td>• Injection of a special dye (Contrast agent) in a vein to see the fluid collecting system of the kidneys and bladder.</td>
<td>Adverse reaction to previous contrast injection: □ Yes □ No Describe:__________________________________________</td>
</tr>
</tbody>
</table>

Do you have allergies? ____________________________________________

Do you have a history of asthma as a child or as an adult? □ Yes □ No

Are you currently taking any of the following? □ Metformin □ Metaglip □ Avandamet □ Glucophage □ Glucovance. (these medications need to be suspended 24 hours prior to intravenous injection of contrast agent.)

Do you have a history of kidney disease? □ Yes □ No If yes, check BUN/Creatinine levels. Creatinin must be below 2.0

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To look for abnormalities in the G.U. System (Kidney, ureters and bladder)</td>
<td>• Allergic reaction varying degree. i.e. Itching, hives, tightness in the throat, difficulty breathing, renal shut-down, shock, and very rarely death</td>
<td>• Miss a kidney tumor, cyst. or stone</td>
<td>• Ultra Sound, CT — without contrast agent at referral site.</td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: □ Yes □ No

If patient is incompetent or a minor, complete the following: **Patient is unable to give consent because:**

__________________________________________________________

__________________________________________________________

I consent to the procedure/operation and sign this of my own free will.

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<tr>
<th>Translator used: □ Yes □ No</th>
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**PATIENT INFORMATION**

Name: __________________________

DOB: ___________ Med Rec #: ___________

DOS: ___________ Encounter: ___________

Residence: __________________________

Facility: __________________________

Translator used: □ Yes □ No

Translator Signature: __________________________

Translator Printed Name: __________________________
PROCEDURE CONSENT

I hereby authorize _________________________________________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Outpatient Oral Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Outpatient Oral Surgery</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Control of infection</th>
<th>relief of pain</th>
<th>preservation of bone</th>
<th>relief of crowding/malalignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>Dry socket or incomplete healing of an extraction site</td>
<td>Bleeding and/or bruising that may be prolonged</td>
<td>Infection</td>
<td>Injury to nerves in or around the mouth that could be permanent</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>Pain, infection</td>
<td>Cyst or tumor formation</td>
<td>Loss of bone around the teeth causing their loss</td>
<td>Increased risk of complications if surgery is postponed to a later date.</td>
</tr>
</tbody>
</table>

| Alternative Treatments | • No treatment, restorative, root canal treatment, referral to a specialist |

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: □ Yes □ No

If patient is incompetent or a minor, complete the following: 

 Patient is unable to give consent because: ________________________________________________

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Control of infection</th>
<th>relief of pain</th>
<th>preservation of bone</th>
<th>relief of crowding/malalignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>Dry socket or incomplete healing of an extraction site</td>
<td>Bleeding and/or bruising that may be prolonged</td>
<td>Infection</td>
<td>Injury to nerves in or around the mouth that could be permanent</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>Pain, infection</td>
<td>Cyst or tumor formation</td>
<td>Loss of bone around the teeth causing their loss</td>
<td>Increased risk of complications if surgery is postponed to a later date.</td>
</tr>
</tbody>
</table>

| Alternative Treatments | • No treatment, restorative, root canal treatment, referral to a specialist |

I consent to the procedure/operation and sign this of my own free will.

__________________________________________ Date & Time

Patient Signature

__________________________ Date and Time

Parent or Guardian Signature

__________________________

Printed Name

__________________________ Date & Time

Signature of Person Obtaining Consent

__________________________ Date & Time

Printed Name

__________________________ Date & Time

Witness Signature

__________________________ Date & Time

Printed Name

__________________________

Translator used: □ Yes □ No

__________________________ Date & Time

Translator Signature

__________________________

Translator Printed Name

Name: ____________________________________________

DOB: ___________________ Med Rec #: _______________

DOS: ___________________ Encounter: ______________

Residence: ______________________________________

Facility: ________________________________________
PROCEDURE CONSENT
I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implanon Insertion</td>
<td>Place a small rod in your LEFT arm for birth control.</td>
</tr>
</tbody>
</table>

_______________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent pregnancy and periods</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarring</td>
</tr>
<tr>
<td>Bleeding</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>May need extra tests to monitor rod.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy, Heavy periods.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCPs, IUD, Depo, Condoms, Etc.</td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: □ Yes □ No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

Signature of Person Obtaining Consent

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
</tr>
</thead>
</table>

Witness Signature

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
</tr>
</thead>
</table>

Translator used: □ Yes □ No

<table>
<thead>
<tr>
<th>Translator Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

PATIENT INFORMATION

Name: ____________________________
DOB: ____________________________  Med Rec #: ____________________________
DOS: ____________________________  Encounter: ____________________________
Residence: ____________________________
Facility: ____________________________
PROCEDURE CONSENT

I hereby authorize __________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implanon Removal</td>
<td>• Remove the Implanon rod from your arm by making a small incision and pulling it out.</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Remove the Implanon rod</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bleeding</td>
</tr>
<tr>
<td>• Infection</td>
</tr>
<tr>
<td>• Scar</td>
</tr>
<tr>
<td>• Discomfort</td>
</tr>
<tr>
<td>• Bruising</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implanon will stay in your arm providing birth control</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Watching and waiting</td>
</tr>
<tr>
<td>• Treating bleeding with birth control pills.</td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent. I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  [ ] Yes  [ ] No

If patient is incompetent or a minor, complete the following: Patient is unable to give consent because:

________________________________________________________________________
________________________________________________________________________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature __________________________ Date & Time __________________________

Parent or Guardian Signature __________________________ Date and Time __________________________

Printed Name ______________________________________

Signature of Person Obtaining Consent __________________________ Date & Time __________________________

Printed Name ______________________________________

Witness Signature __________________________ Date & Time __________________________

Printed Name ______________________________________

Translator used:  [ ] Yes  [ ] No

Translator Signature __________________________ Date & Time __________________________

Translator Printed Name __________________________

PATIENT INFORMATION

Name: ______________________________________
DOB: __________ Med Rec #: ______________________
DOS: __________ Encounter: ______________________
Residence: ______________________________________
Facility: ______________________________________
My medical provider has explained to me that I will have an operation, diagnostic or treatment procedure. I understand the risks of the procedure and have been advised of alternative treatments and the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my medical provider can perform the operation or procedure.

I understand that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anesthesia can occur and include the remote possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been explained to me by my anesthesia provider as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service used for my procedure is determined by many factors including my physical condition, the type of procedure my medical provider is to do, his or her preference, as well as my own desire.

It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

I hereby consent to the following anesthesia service: ________________________________ and authorize that it be administered by ________________________________ or his/her associates, all of whom are credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed (or write “none”)

I certify and acknowledge and accept that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

__________________________________________________________________________

__________________________________________________________________________

PATIENT INFORMATION

Name: __________________________________________
DOB: ____________ Med Rec #: ____________
DOS: ____________ Encounter: ____________
Residence: __________________________________________
Facility: __________________________________________

Translator used: [ ] Yes [ ] No

Translator Signature ___________________________ Date & Time ____________
Translator Printed Name: ____________________________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ___________________________ Date & Time ____________

Printed Name: __________________________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ____________

Printed Name: __________________________________________

Witness Signature ___________________________ Date & Time ____________

Printed Name: __________________________________________

Frm#: YK00142_v5.p32 Rev. Date 10-01-19

08-03-10
I consent to the procedure/operation and sign this of my own free will.

Patient Signature __________________________ Date & Time __________________________

Parent or Guardian Signature __________________________ Date and Time __________________________

Printed Name __________________________

Signature of Person Obtaining Consent __________________________ Date & Time __________________________

Printed Name __________________________

Witness Signature __________________________ Date & Time __________________________

Printed Name __________________________

Translator used: [ ] Yes [ ] No

Translator Signature __________________________ Date & Time __________________________

Translator Printed Name __________________________

---

If patient is incompetent or a minor, complete the following: **Patient is unable to give consent because:**

---

**PATIENT INFORMATION**

Name: __________________________

DOB: __________________________ Med Rec #: __________________________

DOS: __________________________ Encounter: __________________________

Residence: __________________________

Facility: __________________________

---

**PROCEDURE CONSENT**

I hereby authorize __________________________

and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnostic Hysteroscopy</td>
<td>• Place a lighted scope in uterus to look at the lining</td>
</tr>
<tr>
<td></td>
<td>• Dilate cervix and empty contents of uterus, scraping out uterus and cervix</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Find the cause of abnormal bleeding</td>
<td>• Infection</td>
</tr>
<tr>
<td></td>
<td>• Heavy bleeding requiring blood transfusion</td>
</tr>
<tr>
<td></td>
<td>• Perforate uterus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infection, bleeding</td>
<td>• Medication</td>
</tr>
<tr>
<td></td>
<td>• Hysterectomy</td>
</tr>
</tbody>
</table>

---

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

---

**I consent to the procedure/operation and sign this of my own free will.**
PROCEDURE CONSENT

I hereby authorize ___________________________ to perform the following operation or procedure:

Technical Description:  Nitrous Oxide/Oxygen mixture for labor analgesia

Lay Description:  "Laughing Gas" mixed with oxygen

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent. I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  

If patient is incompetent or a minor, complete the following:

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ___________________________ Date & Time ____________

Parent or Guardian Signature ___________________________ Date and Time ____________

Printed Name ___________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ____________

Printed Name ___________________________

Witness Signature ___________________________ Date & Time ____________

Printed Name ___________________________

Translator used:  Yes  No

Translator Signature ___________________________ Date & Time ____________

Translator Printed Name ___________________________

PATIENT INFORMATION

Name: ___________________________

DOB: ____________ Med Rec #: ____________

DOS: ____________ Encounter: ____________

Residence: ___________________________

Facility: ____________

I consent to the procedure/operation and sign this of my own free will.

Patient Signature ___________________________ Date & Time ____________

Parent or Guardian Signature ___________________________ Date and Time ____________

Printed Name ___________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ____________

Printed Name ___________________________

Witness Signature ___________________________ Date & Time ____________

Printed Name ___________________________

Translator used:  Yes  No

Translator Signature ___________________________ Date & Time ____________

Translator Printed Name ___________________________
PROCEDURE CONSENT

I hereby authorize ____________________________
and such assistants as he/she may designate, to perform the following operation or procedure:

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>• Vasectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Remove a piece of each tube which carries sperm</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

**Purpose**
- • Prevent pregnancy in partner

**Potential Risks**
(Not necessarily all of them)
- • Infection
- • Bleeding
- • Swelling
- • Hematoma
- • Failure

**Risks of not having the procedure**
- • Ongoing risks of contraception or pregnancy in partner

**Alternative Treatments**
- • Various contraceptive methods

---

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure-operation and to ask questions.

I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: [ ] Yes [ ] No

If patient is incompetent or a minor, complete the following: **Patient is unable to give consent because:**

__________________________

---

**PATIENT INFORMATION**

Name: ____________________________
DOB: ____________________ Med Rec #: ____________________
DOS: ____________________ Encounter: ____________________
Residence: ____________________
Facility: ____________________

---

I consent to the procedure/operation and sign this of my own free will.

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Translator used: [ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

---

Frm#: YK00142_v5.p35 Rev. Date 10-01-19
PROCEDURE CONSENT
I hereby authorize _________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

Technical Description

<table>
<thead>
<tr>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injecting medicine into joint.</td>
</tr>
</tbody>
</table>

________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease pain and inflammation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection, bleeding, bruising, pain</td>
</tr>
<tr>
<td>No improvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Symptomatic treatment</td>
</tr>
</tbody>
</table>

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe: □ Yes □ No

If patient is incompetent or a minor, complete the following:

Patient is unable to give consent because:

_________________________________________________________________________

I consent to the procedure/operation and sign this of my own free will.

____________________________  ______________________________
Patient Signature Date & Time

____________________________  ______________________________
Parent or Guardian Signature Date and Time

____________________________
Printed Name

____________________________  ______________________________
Signature of Person Obtaining Consent Date & Time

____________________________
Printed Name

____________________________  ______________________________
Witness Signature Date & Time

____________________________
Printed Name

____________________________  ______________________________
Translator Signature Date & Time

____________________________
Translator Printed Name

PATIENT INFORMATION

Name: __________________________
DOB: __________________________ Med Rec #: __________________________
DOS: __________________________ Encounter: __________________________
Residence: __________________________
Facility: __________________________

Translator used: □ Yes □ No

____________________________  ______________________________
Translator Signature Date & Time

____________________________
Translator Printed Name
To the patient considering the Essure System for Permanent Birth Control ("Essure")

The review and completion of this document is a critical step in helping you decide whether or not to have Essure implanted. You should carefully consider the benefits and risks associated with the device before you make that decision. After reviewing this information, please read and discuss the items in this checklist with your doctor. You should not initial or sign the document, and should not undergo the procedure, if you do not understand each of the elements listed below.

Birth Control Options
I understand that Essure is a permanent form of birth control (referred to as "sterilization"). I understand that sterilization must be considered permanent and not reversible.
I was told about other permanent sterilization procedures, such as surgical bilateral tubal ligation ("getting tubes tied"), and their benefits and risks.
I am aware that there are highly effective methods of birth control that are not permanent, and which may allow me to become pregnant when stopped.

Requirements for Essure Placement and Reliance
I understand that I am not a candidate for Essure if:
• I am uncertain about ending my fertility.
• I have had a tubal ligation procedure ("tubes tied").
• I cannot have two inserts placed due to my anatomy.
• I am pregnant or suspect that I may be pregnant.
• I have delivered or terminated a pregnancy within the last 6 weeks.
• I have had a pelvic infection within six weeks prior to the date of the scheduled implantation.
• I have a known allergy to contrast dye used during x-ray procedures.

Essure works as intended only when the devices are successfully placed in both fallopian tubes. I understand that if this is not possible in my case, I may need to undergo a repeat attempt at Essure placement or consider a different form of birth control.
I understand that the placement procedure is only the first step in relying on Essure for birth control.

After placement:
• I must: use an alternative form of birth control until my doctor tells me I can stop (typically for 3 months).
• Schedule and undergo a confirmation test after three months to determine whether I may rely on Essure.

I understand that payment for this test may or may not be covered by my insurance company.
I understand that a satisfactory confirmation test is needed before I can rely on Essure alone. I also understand that after the confirmation test my doctor may inform me that I may not be able to rely on Essure. If this occurs, I will have to use an alternative form of contraception.
I understand that based on clinical studies, approximately 8% of women who undergo attempts at Essure placement are not able to rely on the device for contraception.

Patient Initials ______

Pregnancy Risks
I understand that no form of birth control is 100% effective. Even if my doctor tells me I am able to rely on Essure, there is still a small chance that I may become pregnant.
Based on clinical studies, the chance of unintended pregnancy for women who have been told they can rely on Essure is less than 1% at 5 years.
I understand that the risks of Essure on a developing fetus have not been established.
If I become pregnant with Essure, there may be an increased risk for the pregnancy to occur outside of the uterus ("ectopic pregnancy"). This may result in serious and even life-threatening complications.
I understand that after Essure placement, I should contact my doctor immediately if I think I may be pregnant.

Patient Initials ______

What to Expect During the Procedure and the Days Afterwards
I understand that in clinical studies supporting device approval, the following events were reported to occur during the Essure placement procedure and/or in the hours or days following placement:
• Cramping (Reported in up to 30% of procedures)
• Mild to moderate pain (Up to 9–10%) or moderate pain (Up to 13%)
• Nausea/Vomiting (Up to 11%)
• Dizziness/Lightheadedness (Up to 9%)
• Vaginal bleeding (Up to 7%)

If I experience worsening of any of the events listed above or I continue to have the symptoms 1 week after placement, I understand that I should contact my doctor.

Patient Initials ______

Long-Term Risks
I understand that some women may experience continued pain or develop new pain after Essure placement.
I understand that I should contact my doctor if abdominal, pelvic or back pain continues for more than 1 week after placement or if I develop the onset of new pain more than 1 week after placement.
I understand that the Essure implants contain metals including nickel, titanium, iron, chromium, and tin, as well as a material called polyethylene terephthalate (PET).
I understand that some women may develop allergic reactions to the device following implantation and have signs or symptoms such as rash and itching. This may occur even if there is no prior history of sensitivity to those materials. I also understand that there is no reliable test to predict ahead of time who may develop a reaction to the device.

Continues...
I understand that persistent or new pain, and/or allergic reaction may be a sign of an Essure-related problem that might require further evaluation and treatment, including possibly the need to have the devices removed by surgery. I recognize that other symptoms have been reported to FDA by women implanted with Essure, although they were not seen in the clinical trials supporting Essure approval. The more common symptoms reported include headache, fatigue, weight changes, hair loss and mood changes such as depression. It is unknown if these symptoms are related to Essure or not.

I understand that because Essure contains metals, I should tell all my doctors that I have the Implant.

I understand that there is a small possibility that the device could poke through the wall of the uterus or fallopian tubes ("perforation"), and/or move to other locations in the abdomen or pelvis ("migration"). The rate of perforation in studies has ranged from 1% to 4%. The rate for device migration into the abdomen or pelvis has not been determined but its occurrence is uncommon.

I understand that should one of these events occur, the device may become ineffective in preventing pregnancy and may lead to serious adverse events such as bleeding or bowel damage, which may require surgery to address.

I understand that should my doctor and I decide that Essure should be removed after placement, a surgical procedure will be required. In complicated cases, my doctor may recommend a hysterectomy (removal of the entire uterus).

I also understand that device removal may not be covered by my insurance company.

Patient Initials ______
Your Physician, Dr. ________________________________ has ordered an x-ray examination which may (or may not) involve the intravenous injection or oral administration of contrast material (dye) into the body. It is important that you are aware of possible side effects and complications involved. A partial list includes flushing, nausea, vomiting, itching, runny nose and eyes, and hives. More serious side effects occur less often, and these are pain and shock. Very, very rarely, death may occur.

1. Have you had any previous contrast injections?  
   - Yes  
   - No
   - Unknown

2. If yes, for what kind of study?  
   - IVP  
   - CT  
   - Unknown

3. Any adverse reactions from the injection?  
   If so, describe: ________________________________

4. Any history of allergy?  
   - Yes  
   - No

5. Any known allergy to Iodine?  
   - Yes  
   - No

For Technologist (to be performed prior to contrast administration)

- Check 2 patient identifiers
- Perform medicine reconciliation
- Perform time out
- First Dose Review performed by ____________________________  
  - Title: ____________________________
- Creatinine level (0.6 to <1.3) (If indicated review Contrast Policy)
- Medication type and Dose ____________________________
- Double-checked by: (IV administration only) ____________________________
  - Administered by: ____________________________

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.

I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

Clinical students may observe:  
   - Yes  
   - No

If patient is incompetent or a minor, complete the following:  
   Patient is unable to give consent because:
   ____________________________________________
   ____________________________________________

I consent to the procedure/operation and sign this of my own free will.

__________________________   ____________________________  
Patient Signature  Date & Time

__________________________   ____________________________  
Parent or Guardian Signature (under 18 yrs)  Date and Time

__________________________  
Patient, Parent or Guardian Printed Name

Translator used:  
   - Yes  
   - No

__________________________   ____________________________  
Translator Signature  Date & Time

__________________________  
Translator Printed Name

PATIENT INFORMATION

Name: ____________________________________________

DOB: ________________  Med Rec #: __________________

DOS: ________________  Encounter: _________________

Residence: _______________________________________

Facility: _________________________________________
After cesarean section, a woman may choose to have a planned cesarean birth or choose a trial of labor for vaginal birth. It is likely that 60-80% of women who try a vaginal birth after cesarean section (VBAC) will be successful. We want you to understand the benefits and risks of your choices. There is risk that goes along with every pregnancy. We share the same goal as you: a healthy baby delivered to a healthy mom. We will make every effort to ensure this. VBAC means Vaginal Birth After Cesarean Section.

What are the benefits of VBAC compared to a planned cesarean birth?
- Faster time to heal after birth
- Shorter hospital stay
- Less risk of infection after delivery
- No chance of problems caused by surgery (infection, injury to bowel or urinary tract, or blood loss)
- Less risk that the baby will have breathing problems
- Quicker return to normal activities because there is no pain from surgery.
- Greater chance of having a vaginal birth in later pregnancies
- Less risk of problems with how the placenta attaches in future pregnancies.

What are the risks of VBAC?
- A tear or opening in the uterus (womb) occurs in 5 to 10 women out of every 1,000 low risk women who try VBAC (0.5% to 1.0%).

Risks to the mother if there is a tear in the uterus include:
- Blood loss that may need transfusion
- Damage to the uterus that may need hysterectomy (removal of the uterus)
- Damage to the bladder
- Infection
- Blood clots
- Death, which is very rare.

Risks to the baby if there is a tear of the uterus are brain damage and death. Not all tears in the uterus harm the baby. About 7% of the time the baby is harmed when the uterus tears. In other words, 5 to 10 babies out of every 10,000 VBAC tries will suffer brain damage or death (0.05% to 0.1%) due to uterine rupture.

I understand that Yukon Delta Regional Hospital (YKDRH) has anesthesia staff, a doctor for the baby and operating room services available 24 hours a day. The risk of a tear in the uterus and how far along labor has gone will be used to decide if all of these people are present in the hospital. In cases of a tear in the uterus, injury to the baby may occur. The risk of injury to the baby increases with the time it takes to deliver the baby and the damage to the placenta. (YKDRH has specific plans to respond once a problem is detected. However, there is risk associated with every pregnancy. Risk can never be completely removed.

I also can decide to have the baby at a hospital where anesthesia, operating room staff, and a doctor for the baby are always there in the hospital. This may lower the risk to the baby if there is a tear in the uterus, but not in all cases. Delivery at another hospital may mean travel during labor and having my baby away from my local community and support system. Changing care from one hospital to another during labor may be of little benefit and may increase the risk of a bad outcome for you and your baby.

Please check on the lines and then sign.

☐ I have read this consent form. I understand the benefits and risks with a planned cesarean section and VBAC. I understand how these benefits and risks apply to me.

☐ I have had the chance to read the VBAC patient education material and ask questions. My questions were answered to my satisfaction.

☐ I understand and accept the labor and delivery services this hospital has to offer.

☐ If I choose a VBAC, this consent will be reviewed as needed during the labor. I may want to ask for a repeat cesarean section or my doctor may find a need to deliver my baby by cesarean section.

☐ I have chosen to try a VBAC for delivery of my baby.

☐ I have chosen to try a VBAC if I go into labor prior to my planned cesarean section.

☐ I have chosen a planned cesarean section.

Patient Signature __________________________ Date/Time __________________________

Printed Name __________________________

Provider Signature __________________________ Date/Time __________________________

Printed Name __________________________

Signature of Witness __________________________ Date/Time __________________________

Printed Name __________________________

Yukon-Kuskokwim HEALTH CORPORATION

Consent for Birth After Cesarean Section

vbac consent-esig-022415-504-RB.pdf Form #: YK00504_v3.ob Rev. Date: 02-24-15
I. POLICY:

A. General consent must be obtained from all adult patients with decision-making capacity, or person legally authorized to consent on behalf of the patient. However, informed consent must be obtained before the performance of a procedure, or the administration of a treatment, anesthesia, or blood or blood products, or the disposal of tissues or body parts. If consent is not obtained, the reasons must be documented in the patient’s medical record.

B. All circumstances and questions cannot be anticipated before they arise, therefore this policy does not presume to address all possible situations concerning issues of patient consent. This document does not address consent for participation in clinical research or clinical trials that are governed by the Human Studies Committee. Consent for psychiatric treatment—voluntary and involuntary—will be obtained in accordance with the Alaska Mental Health Code. Legal Counsel, Compliance and the Risk Management Office are available to clarify information and answer questions.

II. PURPOSE:

The purpose of this policy is to provide guidelines and definitions of various consents, describe when consents are required, define who may sign the consent and to define what invasive procedures require a special consent.

III. DEFINITION:

A. Adult: A person 18 years of age or older or a person under 18 years of age who has the disabilities of minority removed.

B. Attending Provider: The physician with primary responsibility for a patient’s treatment and care.

C. Decision-Making Capacity: The ability to understand and appreciate the nature and consequences of a decision regarding medical treatment and the ability to reach an informed decision in the matter.

D. Incapacitated: Lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision.

E. Informed Consent: Consent for treatment/procedure from a competent patient or authorized person not acting under duress, fraud, or undue pressure; and, who is adequately informed by the healthcare worker of the following information concerning the contemplated procedure/treatment:

1. The patient’s diagnosis.
2. The general nature of the contemplated procedure, its purpose, whether it is experimental, and the name(s) of the person(s) who will perform the procedure or administer or direct the treatment.
3. The benefits, risks, discomforts, and complications associated with the procedure, recuperation that may reasonably be expected, including all risks of the procedure or treatment, the likelihood of success.
4. The patient’s prognosis if the procedure is not performed.
5. Reasonable alternative medical treatments, if any.

F. Expressed Consent: Either oral or written consent given by a competent person or authorized representative for incapacitated patient.

1. Oral consent – Consent conveyed through speech.
2. Written consent – Consent conveyed through written documentation. There are two types of Written Consent: (1) General Written Consent for Diagnosis and Treatment, and (2) Written Consent for Specific Medical and Surgical Procedures.
F. **Implied Consent:** Consent that may be inferred by the patient’s behavior (e.g., a patient extending his arm for blood to be drawn). Implied consent is rarely documented and may be relied upon only for care or treatment that is routine and does not involve significant risk(s). Implied consent may not be relied on for HIV testing.

IV. **PROCEDURE:**

A. **Who May Consent**
   1. To obtain consent for the treatment of an incapacitated adult patient the patient’s legal guardian or properly appointed power of attorney, if one, may give consent for treatment on behalf of the patient.
   2. Note: Family relationships (including spouse) do not, by themselves, make one person the legal agent of another.
   3. When there is not an agent appointed in a medical power of attorney or guardian to consent on behalf of an adult patient who is comatose, incapacitated, or otherwise mentally or physically incapable of communication, an adult from the following list, who has decision-making capacity, is available after a reasonably diligent inquiry, and is willing to consent to medical treatment on behalf of the patient, in order of priority, may act as the “surrogate decision maker”:
      4. patient’s spouse
      5. an adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;
      6. a majority of the patient’s reasonably available adult children;
      7. patient’s parent(s); or
      8. the individual clearly identified to act for the patient (before the patient’s incapacity), the patient’s nearest living relative.

B. **Surrogate Decision Maker**
   1. In order to consent on behalf of the incapacitated adult patient, the patient, the surrogate: may not, under any circumstance, consent to voluntary inpatient mental health services, or the appointment of another surrogate.
   2. Any dispute to the voluntary right of a party to act as the patient’s surrogate must be resolved by the court having probate jurisdiction. Any decision by a surrogate must be based on knowledge of what the patient would desire, if known.

C. **Provider Documentation**
   1. The attending physician shall document
   2. The patient’s comatose state, incapacity, or other inability to communicate in the patient’s medical record;
   3. The proposed medical treatment;
   4. The diligent efforts to contact or cause to be contacted persons eligible to serve as the patient’s surrogate decision-makers; and
   5. The date and time of consent if a surrogate decision maker consents to medical treatment on behalf of the patient, including the attending physician’s signature.
   6. If the consent is not made in person, the surrogate decision maker’s consent shall be reduced to writing in patients medical record, signed by the hospital staff member receiving the consent, and countersigned in the patient’s medical record or on an informed consent form by the surrogate decision-maker.

D. **General Rules Regarding Consent**
   1. General written consent for diagnosis and routine hospital must be obtained upon each patient’s admission to the hospital whether for a fixed or indefinite stay (e.g., an admission to the Emergency Department for 3 hours or longer or to Ambulatory Surgery for 1 day versus inpatient admission for an indefinite stay).
   2. **Significantly invasive procedures, surgical procedures, and procedures requiring moderate sedation, general anesthesia or spinal/epidural anesthesia require informed consent on standardized preprinted forms.**
   3. Minor procedures do not require preprinted standard written consent. Risks and benefits of any procedure will be discussed with patients. Documentation of discussion of such procedures in a note is encouraged.
   4. Preprinted Informed consent forms will have risks and benefits of the procedure/surgery clearly defined.
   5. MSEC will determine which procedures/surgeries require prewritten consents and will approve content of the consents. Requests for new consents will be forwarded to MSEC for consideration and approval if appropriate.
   6. All approved consent forms will be reviewed and revised at least every three years and as needed. The revision date will be documented on the form.
   7. Consents will be available to all staff on units and on line.

Standard reference: JCAHO (TX.)
Written by: Vivian Lee, Chief Nurse Executive
Attachment A
MSEC Approved Consents

- Blank Form
- BMT
- C-Section
- Circumcision
- Colonoscopy
- Colposcopy
- Endometrial Biopsy
- Sedation Analgesia
- Cystoscopy
- Dilation & Curettage
- Dental Reh
- EGD
- External Cephalic Version
- Excisional Biopsy
- Exercise Stress Test
- Flex Sig
- I & D OR
- IUD Placement
- IVP
- LEEP
- Lumbar Puncture
- Mesiodens
- Tubal Laparoscopy
- Tubal Mini Lap
- Tubal PPBTL

Attachment B

<table>
<thead>
<tr>
<th>IDENTITY OF PERSON SIGNING</th>
<th>PROOF REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
</tr>
<tr>
<td>&gt; 18/yo + Competent</td>
<td>ID Card or Staff Personally Knows the Patient</td>
</tr>
<tr>
<td>&gt; 16 y/o but &lt; 18 y/o + Emancipated</td>
<td>ID Card &amp; Court Order of Emancipation Marriage Certificate</td>
</tr>
<tr>
<td>&gt; 16 y/o but &lt; 18y/o + Reproductive Health</td>
<td>ID Card and Wishes Reproductive Health Services Records for which there is a Restriction</td>
</tr>
<tr>
<td>Parent of a Minor (Minor = individual &lt; 18 y/o) Note: A Minor who is the Parent of a child may consent to care for themselves and the child</td>
<td>ID Card or Staff Personally Knows the Patient</td>
</tr>
<tr>
<td>Relative or Next of Kin (this is for help in identifying missing persons only)</td>
<td>ID Card + Government Agent Involvement</td>
</tr>
<tr>
<td>Guardian of a Patient who can be a minor or adult</td>
<td>ID Card &amp; Court Order of Guardianship, Custody, Detention or Copy of Will</td>
</tr>
<tr>
<td>DFYS or Other Third Party Guardian</td>
<td>ID Card &amp; Court Order or Will</td>
</tr>
<tr>
<td>Relative with Custody, Foster Parent or others with “in loco parentis” status</td>
<td>ID Card &amp; Court Order or Signed &amp; Notarized Special Power of Attorney (POA) for Custody &amp; Care of Minor</td>
</tr>
<tr>
<td>Prisoner under Custody of State or Federal Prison</td>
<td>ID Card &amp; Detention Order</td>
</tr>
<tr>
<td>Conservator of a Patient who can be a minor or adult (this is for Financial Information Only)</td>
<td>ID Card &amp; Court Order of Conservator or Copy of Will</td>
</tr>
<tr>
<td>Attorney In Fact (Person with Power of Attorney)</td>
<td>ID Card &amp; Court Order of Guardianship, Custody, Detention or Copy of Will</td>
</tr>
<tr>
<td>General or Specific Power of Attorney for Competent Patient (Adult or Emancipated Minor)</td>
<td>ID Card &amp; Copy of Power of Attorney</td>
</tr>
<tr>
<td>Executor or Administrator of Deceased Individual’s Estate*</td>
<td>ID Card &amp; Letter of Appointment of Administrator or Executor (from Registrar) or Court Order. Next of Kin - document relationship.</td>
</tr>
</tbody>
</table>

(Footnotes)

* Relative or Next of Kin includes spouses, children, parents, aunt, uncle, nephew, niece, in order of priority.