Special Consent Forms for Operations or Other Procedures
Rev. 062615

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.

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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>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
</tr>
</tbody>
</table>

_________________________ has discussed with me the information briefly summarized below:

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

_________________________ 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

Name: __________________________
DOB: __________________________
DOS: __________________________
Residence: _______________________
Facility: _______________________

Printed Name
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:

__________________________________________

__________________________________________

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>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Right</td>
<td>□ Insert Tubes into the ears</td>
</tr>
<tr>
<td>□ Left</td>
<td></td>
</tr>
<tr>
<td>□ Bilateral</td>
<td></td>
</tr>
<tr>
<td>Myringotomy with Insertion of Vented Tubes</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

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

Translated by: __________________________ 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: __________________________
# Cesearean Section 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>Primary</td>
<td>Repeat</td>
</tr>
<tr>
<td>Make an incision in the abdomen and womb to allow surgical delivery of the baby</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>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>To maximize the safety of the delivery for the baby and the mother.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
</tr>
<tr>
<td>Bleeding possibly requiring a blood transfusion</td>
</tr>
<tr>
<td>Infection</td>
</tr>
<tr>
<td>Perforation of an internal organ which may require transfer to Anchorage for surgery</td>
</tr>
<tr>
<td>Cesearean Hysterectomy</td>
</tr>
<tr>
<td>A laceration to the baby</td>
</tr>
<tr>
<td>In very rare cases death to the baby or mother.</td>
</tr>
</tbody>
</table>

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

### Alternative Treatments

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>

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

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

### PATIENT INFORMATION

- **Name:** ___________________________
- **DOB:** _______  **Med Rec #:** _______
- **DOS:** _______  **Encounter:** _______
- **Residence:** ___________________________________________
- **Facility:** ___________________________________________

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>

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Frm#: YK00142_v4.p5  |  Rev. Date: 06-26-15
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

_______________________________
______________________________
Witness Signature  Date & Time

_______________________________
______________________________
Printed Name

Translator used:

_______________________________
______________________________
Translator Signature  Date & Time

_______________________________
______________________________
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

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:  

 darkest Yes  No

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

Patient is unable to give consent because:  

_______________________________
______________________________
Printed Name

PATIENT INFORMATION

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

Translator used:

_______________________________
______________________________
Translator Signature  Date & Time

_______________________________
______________________________
Printed Name

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 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:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
**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>• Colposcopy with Cervical Biopsy and Endocervical Curretage</td>
<td>• Looking for abnormal cells on the opening of my cervix or womb that could turn into precancer or cancer</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>• 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</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bleeding, Infection</td>
<td>• Missing an abnormal area that exists.</td>
</tr>
<tr>
<td></td>
<td>• Vaginal discharge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Failure to diagnose a pre-cancer or cancer that requires treatment.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Observation without treatment</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:

_________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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</td>
<td></td>
</tr>
</tbody>
</table>

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

Printed Name

Witness Signature

Date & Time

<table>
<thead>
<tr>
<th>Printed Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator used:  Yes  No</td>
<td></td>
</tr>
</tbody>
</table>

Translator Signature Date & Time

Translator Printed Name

Registrar: ____________________________

_________________________
**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</td>
<td>• Bleeding and infection</td>
</tr>
<tr>
<td>(not necessarily all of them)</td>
<td></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.

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

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>
</tbody>
</table>

**PATIENT INFORMATION**

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

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>

Frm#: YK00142_v4.p9  Rev. Date: 06-26-15
# Dental Rehabilitation 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>• 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 fluorides, 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>

### Purpose
- To improve the oral health of the patient.

### Potential Risks
(Not necessarily all of them)
- Allergic reaction
- Swelling, pain, infection, fever, vomiting
- Damage to developing permanent teeth especially when extracting unerupted teeth
- Dental space loss.

### Risks of not having the procedure
- Progression of the existing dental disease and/or infection
- Infection, pain, swelling, fever
- Difficulty eating and/or sleeping
- Damage or disruption of developing permanent teeth.

### Alternative Treatments
- Two or more difficult dental appointments with or without restraints and/or light sedation.

---

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>

---

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

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB:</td>
<td>Med Rec #:</td>
</tr>
<tr>
<td>DOS:</td>
<td>Encounter:</td>
</tr>
<tr>
<td>Residence:</td>
<td></td>
</tr>
<tr>
<td>Facility:</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>
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>• Dilation and Curettage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Dilate cervix and empty contents of uterus with suction and scraping out uterus</td>
</tr>
</tbody>
</table>

______________________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• Remove non-living pregnancy to prevent infection and bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>• Infection  • Heavy bleeding requiring blood transfusion  • Perforate uterus</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>• Infection, Bleeding</td>
</tr>
<tr>
<td>Alternative Treatments</td>
<td>• Waiting for uterus to pass pregnancy on its own</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>
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<th>Patient Signature</th>
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</thead>
<tbody>
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<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
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<tr>
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<td></td>
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<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>
</tbody>
</table>

PATIENT INFORMATION

| Name: ____________________________ | |
| DOB: ____________________________ | Med Rec #: ____________________________ |
| DOS: ____________________________ | Encounter: ____________________________ |
| Residence: ______________________ | |
| Facility: ________________________ | |

Translator used: [ ] Yes [ ] No

<table>
<thead>
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<th>Translator Signature</th>
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</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**
- EGD (esophagogastroduodenoscopy) with possible biopsy and/or polyp removal and possible therapeutic injection
- Procedural sedation
- Picture taking for medical documentation

**Lay Description**
- Look in the esophagus, stomach and duodenum with a flexible camera.
- Take pieces of tissue, remove growths, and inject medicine if needed to stop bleeding.
- Give medications to make you sleepy and more comfortable during the procedure.

_______ has discussed with me the information briefly summarized below:

**Purpose**
- To examine your esophagus, stomach and duodenum for cancer, polyps (growths), ulcers, bleeding, and infection.

**Potential Risks**
- Drug reaction including allergic reaction, low blood pressure, difficulty breathing, and death.
- Bleeding which can occur immediately or later after you are discharged.
- Perforation (causing a hole in the esophagus, stomach, and/or duodenum).
- Missing an ulcer, growth or cancer.
- Inability to complete the procedure requiring additional testing (such as a barium swallow).
- If a complication occurs, you might need a blood transfusion, you might need to be hospitalized or medevaced to Anchorage for surgery, and you could possibly die.

**Risks of not having the procedure**
- Undetected bleeding, ulcers, infection, and cancer resulting in delayed treatment.

**Alternative Treatments**
- Barium swallow (an X-ray of the esophagus, stomach and duodenum)
- No sedation
- Medical treatment without endoscopy

---

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: ____________________________

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Translator used: ☐ 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 ____________________________

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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>• Endometrial Biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</td>
<td>• Put a small tube in my uterus or womb to scrape or suction the lining</td>
</tr>
</tbody>
</table>

_______________________________
Patient Signature Date & Time

_______________________________
Parent or Guardian Signature Date and Time

_____________________________________________
Printed Name

_______________________________
Signature of Person Obtaining Consent Date & Time

_______________________________
Witness 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

If patient is incompetent or a minor, complete the following:
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I consent to the procedure/operation and sign this of my own free will.

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Translator used: □ Yes □ No

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Frm#: YK00142_v4.p13 Rev. Date: 06-26-15
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>• Place Essure inserts in fallopian tubes using a hysteroscope</td>
<td>• Place small spring-like devices in tubes using a lighted scope.</td>
</tr>
<tr>
<td></td>
<td>• Essure is permanent and CANNOT be reversed.</td>
</tr>
<tr>
<td></td>
<td>• You MUST have a confirmation test in 3 months to confirm tube blockage.</td>
</tr>
<tr>
<td></td>
<td>• You MUST use birth control until the confirmation test is done.</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

### Purpose
- Prevent pregnancy

### Potential Risks (not necessarily all of them)
- Pregnancy, no birth control is 100%. This is 99.8% with a confirmation test.
- Bleeding, infection, damage to the uterus, allergic reaction or cramping.
- Failure to place the inserts.

### Risks of not having the procedure
- Pregnancy

### Alternative Treatments
- Tubal ligation through abdominal surgery

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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Frm#: YK00142_v4.p14  Rev. Date: 06-26-15
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>• Excisional Biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</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>• To remove abnormal growths and/or test tissue for diagnostic purposes</th>
</tr>
</thead>
</table>
| Potential Risks (not necessarily all of them) | • Infection, scarring,  
• Failure to remove lesion entirely, and re-growth of lesion  
• Reaction to local anesthetic  
• Need for wider excision. |
| Risks of not having the procedure | • 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.

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</table>

Signature of Person Obtaining Consent Date & Time
Printed Name

Witness Signature Date & Time
Printed Name

Patient Information
Name: ____________________________
DOB: ____________ Med Rec #: ____________
DOS: ____________ Encounter: ____________
Residence: ____________________________
Facility: ____________________________

Translator used: ☐ Yes ☐ No
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 • 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:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• To evaluate the ability of your heart to respond to exercise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>• In rare cases, such symptoms as abnormal heart rhythms, fainting, heart attacks, and in extremely rare cases, death.</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>• Undiagnosed heart disease with increased risk of death.</td>
</tr>
</tbody>
</table>

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 ___________________________

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PATIENT INFORMATION

Name: ___________________________

DOB: ___________________________ Med Rec #: ___________________________

DOS: ___________________________ Encounter: ___________________________

Residence: ___________________________

Facility: ___________________________

Translator used: □ Yes  □ No

Printer Name ___________________________

Translator Signature ___________________________ Date & Time ___________________________

Translator Printed Name ___________________________
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>
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<tbody>
<tr>
<td>• External Cephalic Version</td>
<td>• Attempt to turn the baby until its head is down by pushing on your abdomen.</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
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<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To move the baby into a position which allows a safe vaginal delivery.</td>
<td>• Changes in the baby’s heart rate which resolve shortly after finishing the procedure</td>
<td>• 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.</td>
<td>• Elective cesarean section</td>
</tr>
<tr>
<td></td>
<td>• Rupture of the bag of waters and starting labor.</td>
<td></td>
<td>• Breech vaginal delivery</td>
</tr>
<tr>
<td></td>
<td>• Very rarely, severe changes in the baby’s heart rate and/or separation of the placenta from the uterus, necessitating an emergency cesarean section.</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.

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Clinical students may observe: [ ] Yes [ ] No

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Residence: ____________________________
Facility: ____________________________

Translators used: [ ] Yes [ ] No

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### 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>• Flexible Sigmoidoscopy with Biopsy with Conscious Sedation</td>
<td>• Look into rectum and large intestine with a telescope to look for bleeding and cancer</td>
</tr>
<tr>
<td>• Take pictures for medical documentataion</td>
<td>• Take pieces of tissue if they look suspicious.</td>
</tr>
<tr>
<td></td>
<td>• Give you medicine to make your sleepy.</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>• To look for cancer and/or bleeding</td>
<td>• Bleeding or perforation of colon possibly requiring blood transfusion, transfer to Anchorage for surgery and possibly resulting in death</td>
<td>• Undetected cancer</td>
<td>• Colonoscopy</td>
</tr>
<tr>
<td></td>
<td>• Possible drug reaction, and/or respiratory arrest.</td>
<td></td>
<td>• Barium Enema</td>
</tr>
<tr>
<td></td>
<td>• There is also a risk of missing polyps or cancer</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:*

________________________________________________________________________

________________________________________________________________________

---

### PATIENT INFORMATION

| Name: ________________________________ | Translator used:  
[ ] Yes    [ ] No |
<table>
<thead>
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<th></th>
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<tbody>
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</table>

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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

__________________________ Date & Time

Printed Name

__________________________ Date & Time

Signature of Person Obtaining Consent

__________________________ Date & Time

Witness Signature

__________________________ Date & Time

Witness Signature
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>
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<tbody>
<tr>
<td>Placement of IUD</td>
<td>Put IUD in uterus to prevent pregnancy</td>
</tr>
</tbody>
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_______________________________ has discussed with me the information briefly summarized below:

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<th>Potential Risks (not necessarily all of them)</th>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
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</table>
| Prevent pregnancy | • 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. | Undesired Pregnancy | • 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.

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PROCEDURE CONSENT

I hereby authorize _________________________________
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<tr>
<th>Technical Description</th>
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<tbody>
<tr>
<td>• LEEP (Loop Electrical Excision Procedure)</td>
<td>• Cut off a piece of the cervix using an electrical cautery device</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:

_______________________________
_____________________________________________
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

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

_______________________________  ___________________________
Patient Signature  Date & Time

_______________________________  ___________________________
Parent or Guardian Signature  Date & Time

_______________________________  ___________________________
Witness Signature  Date & Time

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 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 ____________________________ 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:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• To remove extra teeth.</th>
</tr>
</thead>
</table>
| Potential Risks |  • 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

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 ______________________________________
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>Moderate / Procedural Sedation in the operating room if necessary</td>
<td>Give you medicine to make you sleepy and/or put you to sleep and help you breath in the operating room if necessary.</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>
</table>
| To minimize patient's anxiety and pain to allow performance of a procedure | 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.

__________________________ has discussed with me the information briefly summarized below:

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<tr>
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</tr>
</thead>
</table>
| To minimize patient's anxiety and pain to allow performance of a procedure | Possible drug reaction  
Respiratory arrest possibly requiring intubation  
Hypotension  
Pneumonia  
Failure of sedation  
In extreme rare cases death |

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<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
</table>
| To minimize patient's anxiety and pain to allow performance of a procedure | Possible drug reaction  
Respiratory arrest possibly requiring intubation  
Hypotension  
Pneumonia  
Failure of sedation  
In extreme rare cases death |

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

Translated Name

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

Technical Description
- Laparoscopic Tubal Ligation
- Possible open Tubal Ligation and taking pictures for medical documentation.

Lay Description
- Do surgery to destroy Fallopian tubes to prevent future pregnancy, using a small fiberoptic scope or through a larger abdominal incision if necessary.
- Taking pictures of the procedure for medical documentation.

_________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent future pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>(not necessarily all of them)</td>
<td>Damage to intestines or bladder</td>
</tr>
<tr>
<td></td>
<td>Severe bleeding requiring blood transfusion</td>
</tr>
<tr>
<td></td>
<td>Infection in the wound requiring antibiotics and/or hospitalization</td>
</tr>
<tr>
<td></td>
<td>Scarring and small risk of an ectopic if pregnant.</td>
</tr>
<tr>
<td></td>
<td>Small risk of future pregnancy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy and all of its inherent risk</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>All other birth control methods, including vasectomy for partner.</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>
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<tr>
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<table>
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<tr>
<th>Parent or Guardian Signature</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and Time</td>
<td>_______________________________</td>
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<table>
<thead>
<tr>
<th>Printed Name</th>
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</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Person Obtaining Consent</th>
<th>_______________________________</th>
</tr>
</thead>
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<tr>
<td>Date &amp; Time</td>
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<table>
<thead>
<tr>
<th>Printed Name</th>
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</thead>
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<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>_______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date &amp; Time</td>
<td>_______________________________</td>
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</tbody>
</table>

PATIENT INFORMATION

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

Translator used: ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Translator Signature</th>
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</tr>
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<tr>
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<th>_______________________________</th>
</tr>
</thead>
</table>

Frm#: YK00142_v4.p24 Rev. Date: 06-26-15
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>
<tbody>
<tr>
<td>Lay Description</td>
<td>• An incision is made in the lower abdomen to allow access to your tubes.</td>
</tr>
<tr>
<td></td>
<td>• A piece will be removed from each tube to prevent future pregnancy.</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

_______________________________  ______________________________
Witness Signature  Date & Time

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

Clinical students may observe:  [ ] Yes  [ ] No

Translator used:  [ ] Yes  [ ] No

_____________________________________________
Translator Printed Name

_____________________________________________
Date & Time

PATIENT INFORMATION

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

_____________________________________________
Translator Printed Name

_______________________________  ______________________________
Translator Signature  Date & Time

_______________________________  ______________________________
Translator Printed Name

_______________________________  ______________________________
Translator Signature  Date & Time
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>• Post Partum Tubal Ligation</td>
<td>• 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.</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>• To prevent future pregnancy.</td>
<td>• Bleeding, infection • Injury to internal organs • Removal of round ligament &amp; not tube • in 300 risk of pregnancy in future with risk of ectopic if pregnant</td>
<td>• Pregnancy &amp; all of its inherent risk</td>
<td>• 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.</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>
</tbody>
</table>

If translator used, please indicate:

<table>
<thead>
<tr>
<th>Translator used:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
<td></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:

- Technical Description: Thoracentesis
- Lay Description: Draining lung fluid

_______________________________ ______________________________
Patient Signature  Date & Time

_______________________________ ______________________________
Parent or Guardian Signature Date and Time

_____________________________________________
Printed Name

_______________________________ ______________________________
Signature of Person Obtaining Consent  Date & Time

_____________________________________________
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:

__________________________________________
__________________________________________

---Thoracentesis Consent---

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

---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:

Technical Description • Blood Transfusion

Lay Description • Blood Transfusion

_______________________________ has discussed with me the information briefly summarized below:

Purpose • Increasing oxygen in blood needed to support body functions
• To help stop bleeding by replacing factors and cells in blood.

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

_______________________________

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.

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

Frm#: YK00142_v4.p28 Rev. Date: 06-26-15
**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>• 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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions</th>
<th>Adverse reaction to previous contrast injection: □ Yes □ No Describe:__________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have allergies?</td>
<td></td>
</tr>
<tr>
<td>Do you have a history of asthma as a child or as an adult?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Are you currently taking any of the following?</td>
<td>□ Metformin □ Metaglip □ Avandamet □ Glucophage □ Glucovance. (these medications need to be suspended 24 hours prior to intravenous injection of contrast agent.)</td>
</tr>
<tr>
<td>Do you have a history of kidney disease?</td>
<td>□ Yes □ No If yes, check BUN/Creatinine levels. Creatinin must be below 2.0</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• To look for abnormalities in the G.U. System (Kidney, ureters and bladder)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
<th>• Allergic reaction varying degree. i.e. Itching, hives, tightness in the throat, difficulty breathing, renal shut-down, shock, and very rarely death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks of not having the procedure</td>
<td>• Miss a kidney tumor, cyst. or stone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
<th>• Ultra Sound, CT — without contrast agent at referral site.</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>
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</thead>
<tbody>
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</tr>
<tr>
<td>Witness Signature</td>
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**PATIENT INFORMATION**

Name: ____________________________
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DOS: ____________________________ Encounter: ____________________________
Residence: ____________________________
Facility: ____________________________

Translator used: □ Yes □ No

<table>
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</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**: Outpatient Oral Surgery
- **Lay Description**: Outpatient Oral Surgery

__________________________ 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>
</table>

**Potential Risks** (not necessarily all of them):
- Dry socket or incomplete healing of an extraction site
- Bleeding and/or bruising that may be prolonged
- Infection
- Injury to nerves in or around the mouth that could be permanent
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and an increased risk of complications
- Involvement of sinus near tooth structures
- Injury to nearby teeth or fillings
- Restriction of mouth opening
- Unusual reaction to medications given or prescribed.
- You can expect bleeding, swelling, and/or pain following this procedure.

**Risks of not having the procedure**:
- Pain, infection
- Cyst or tumor formation
- Loss of bone around the teeth causing their loss
- Increased risk of complications if surgery is postponed to a later date.

**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:**

---

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

---

**PATIENT INFORMATION**

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

---

**Translator used:** ☐ Yes ☐ No

---

**Frm#:** YK00142_v4.p30  **Rev. Date: 06-26-15**
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 _______________

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:

Implanon Consent Form

Technical Description • Implanon Insertion

Lay Description • Place a small rod in your LEFT arm for birth control.

_______________________________ has discussed with me the information briefly summarized below:

| Purpose | • Prevent pregnancy and periods |
| Potential Risks (not necessarily all of them) | • Scarring • Bleeding • Infection • May need extra tests to monitor rod. |
| Risks of not having the procedure | • Pregnancy, Heavy periods. |
| Alternative Treatments | • BCPs, IUD, Depo, Condoms, Etc. |

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

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:

<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 ___________________________

-------------------------------------------------

PATIENT INFORMATION

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

Translator used: ☐ Yes ☐ No

Printed Name ___________________________

Translator Signature ___________________________ Date & Time ___________________________

Translator Printed Name ___________________________
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 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 08-03-10

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Diagnostic Hysteroscopy</td>
</tr>
<tr>
<td></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>

_______________________________
____________________________

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

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

Frm#: YK00142_v4.p34  Rev. Date: 06-26-15
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></td>
<td>• Vasectomy</td>
</tr>
<tr>
<td></td>
<td>• Remove a piece of each tube which carries sperm</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 in partner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>(not necessarily all of them)</td>
</tr>
<tr>
<td>• Infection</td>
</tr>
<tr>
<td>• Bleeding</td>
</tr>
<tr>
<td>• Swelling</td>
</tr>
<tr>
<td>• Hematoma</td>
</tr>
<tr>
<td>• Failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ongoing risks of contraception or pregnancy in partner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Various contraceptive methods</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:  

Signature of Person Obtaining Consent  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
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? ☐ Yes ☐ No
   If so, describe: _____________________________________________________________________________________
4. Any history of allergy? ☐ Yes ☐ No
   If yes, to what substances are you allergic? _______________________________________________________________________________________________________
5. Any known allergy to iodine? ☐ Yes ☐ No
6. Any history of asthma either as a child or an adult? ☐ Yes ☐ No
7. Any history of diabetes? ☐ Yes ☐ No
8. If yes, are you taking any medication for diabetes? ☐ Yes ☐ No
   If taking any derivative of Metformin, the patient needs to stop taking this medication for 48 hours after the CT exam and follow up with a provider.
8. Any previous history of heart disease (CHF, angina, cardiomyopathy)? ☐ Yes ☐ No
9. Any history of kidney disease, renal insufficiency or surgery to the kidneys? ☐ Yes ☐ No

Females only:
10. Are you pregnant or think that you may be pregnant? ☐ Yes ☐ No
11. Are you breastfeeding ☐ 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:

| Patient, Parent or Guardian Printed Name |

Translator used:  Yes  No

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

| Translator Printed Name |

PATIENT INFORMATION

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

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 (under 18 yrs)</th>
<th>Date and Time</th>
</tr>
</thead>
</table>

| Patient, Parent or Guardian Printed Name |

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

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

| Translator Printed Name | |

contrastconsent-112714-142-esp.pdf  Frm#: YK00142_v4.rad  Rev. Date: 11-27-14
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
Committee signature: Health Services Team

Approval signature ____________________________
### Attachment A

**MSEC Approved Consents**

- Blank Form
- BMT
- C-Section
- Circumcision
- Colonoscopy
- Colposcopy
- Sedation Analgesia
- Cystoscopy
- Dilatation & 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
- Endometrial Biopsy

### 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/y o + 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)</td>
<td>ID Card or Staff Personally Knows the Patient</td>
</tr>
<tr>
<td>Note: A Minor who is the Parent of a child may consent to care for themselves and the child</td>
<td></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 orCopy 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></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>

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