Special Consent Forms for Operations or Other Procedures
Rev. 020719

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.
**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>
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<table>
<thead>
<tr>
<th>Lay Description</th>
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</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
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<table>
<thead>
<tr>
<th>Potential Risks</th>
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<tbody>
<tr>
<td>(not necessarily all of them)</td>
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<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
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<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
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</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>
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<table>
<thead>
<tr>
<th>Parent or Guardian Signature</th>
<th>Date and Time</th>
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<table>
<thead>
<tr>
<th>Printed Name</th>
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</table>

<table>
<thead>
<tr>
<th>Signature of Person Obtaining Consent</th>
<th>Date &amp; Time</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date &amp; Time</th>
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<tr>
<th>Printed Name</th>
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Translated used: ☐ Yes ☐ No

Translator Signature: __________________________ Date & Time: __________________________

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

**PATIENT INFORMATION**

Name: __________________________

DOB: ______________ Med Rec #: ______________

DOS: ______________ Encounter: ______________

Residence: __________________________

Facility: __________________________
PROCEDE 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>• Incision and Drainage of Abscess in the OR</td>
<td>• Cut open and drain the pus out of the boil in the OR</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Open infected area so it can drain and heal</td>
<td>• Pain&lt;br&gt;• bleeding&lt;br&gt;• possible worsening of infection&lt;br&gt;• scar formation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Worsening of infection</td>
<td>• Hot packs and antibiotics</td>
</tr>
</tbody>
</table>

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

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

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

Clinical students may observe: [ ] Yes   [ ] No

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

__________________________

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

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

Translator used: [ ] Yes   [ ] No

Translator Signature                  Date & Time

Translator Printed Name

PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Med Rec #:</th>
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<tbody>
<tr>
<td>DOB:</td>
<td>Encounter:</td>
</tr>
<tr>
<td>DOS:</td>
<td>Facility:</td>
</tr>
<tr>
<td>Residence:</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>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Right □ Left □ Bilateral Myringotomy with Insertion of Vented Tubes</td>
<td>□ Insert Tubes into the ears</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

_______________________________  ______________________________
Translator Signature  Date & Time

_____________________________________________
Translator Printed Name

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

_______________________________  ______________________________

_______________________________  ______________________________

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

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

Clinical students may observe: □ Yes □ No

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

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<td>Facility</td>
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Frm#: YK00142_v4.p4  Rev. Date 02-07-19
PROCEDURE CONSENT

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

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

________________________ has discussed with me the information briefly summarized below:

### Purpose
- To maximize the safety of the delivery for the baby and the mother.

### Potential Risks
- Pain
- Bleeding possibly requiring a blood transfusion
- Infection
- Perforation of an internal organ which may require transfer to Anchorage for surgery
- Cesearean Hysterectomy
- A laceration to the baby
- In very rare cases death to the baby or mother.

### Risks of not having the procedure
- 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.)

### 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:**

<table>
<thead>
<tr>
<th>I consent to the procedure/operation and sign this of my own free will.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Signature</td>
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<tr>
<td>Witness Signature</td>
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<tr>
<td>Printed Name</td>
</tr>
<tr>
<td>Translator used:  [ ] Yes  [ ] No</td>
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</tbody>
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**PATIENT INFORMATION**

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

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

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

________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For cosmetic reasons</td>
<td>• Bleeding that may require sutures</td>
</tr>
<tr>
<td>• Decreased risk of urinary tract infections, sexually transmitted infections, and penile cancer.</td>
<td>• Infection, bruising, swelling, injury to the penis, and—extremely rarely—death.</td>
</tr>
<tr>
<td></td>
<td>• Undesired cosmetic result requiring revision or additional surgery</td>
</tr>
<tr>
<td></td>
<td>• Risk for decreased sensation of the penis later in life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Small risk of urinary tract infections, sexually transmitted infections, and penile cancer.</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:  

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.

| 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           |                         |

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

<table>
<thead>
<tr>
<th>Translator used:</th>
<th>Yes</th>
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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
• Colonoscopy with possible biopsy or polyp removal
• Procedural sedation
• Picture taking for medical documentation

Lay Description
• Look in the large intestine with a flexible camera and possibly take pieces of tissue and remove growths.
• 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 large intestine for cancer, polyps (growths), bleeding, and infection.

Potential Risks (not necessarily all of them)
• Drug reaction including allergic reaction, low blood pressure, difficulty breathing, and death.
• Bleeding which can occur immediately or even weeks after the procedure.
• Perforation (causing a hole in the intestine) which can occur immediately or be delayed.
• Missing a polyp or cancer.
• Inability to complete the procedure requiring additional testing (such as a barium enema).
• 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 polyps or cancer resulting in delayed treatment

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

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

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

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

Clinical students may observe:  [ ] Yes  [ ] No

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

_______________________________  ______________________________
Patient Signature  Date & Time

_______________________________  ______________________________
Parent or Guardian Signature  Date and Time

_______________________________
Printed Name

_______________________________  ______________________________
Signature of Person Obtaining Consent  Date & Time

_______________________________
Printed Name

_______________________________  ______________________________
Witness Signature  Date & Time

_______________________________
Printed Name

Translator used:  [ ] Yes  [ ] No

_______________________________  ______________________________
Translator Signature  Date & Time

_______________________________
Translator Printed Name

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

_______________________________

PATIENT INFORMATION

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

Frm#: YK00142_v4.p7  Rev. Date 02-07-19
PROCEDURE CONSENT

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

**Technical Description**  • Colposcopy with Cervical Biopsy and Endocervical Curetage

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

________________________ ____________________________
Printer Name
Date & Time

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

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

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

**Alternative Treatments**  • Observation without treatment

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

Clinical students may observe:  Yes  [ ] No  [ ]

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

*Patient is unable to give consent because:*

________________________ ____________________________
Printer Name
Date & Time

**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:

Technical Description:  □ Flexible  □ Rigid Cystoscopy

Lay Description:  • Look into the bladder with a lighted scope

_______________________________  ______________________________
Patient Signature  Date & Time

_______________________________  ______________________________
Parent or Guardian Signature  Date and Time

_______________________________  ______________________________
Witness Signature  Date & Time

_______________________________  ______________________________
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:
• ______________________________________________________________________
• ______________________________________________________________________

__________________________________________
Translator used:  □ Yes  □ No

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

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:

Technical Description
• Complete Dental Rehabilitation in the Operating Room under General Anesthesia
• 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.

Lay Description
• Dental treatment while the patient is asleep, including, but not limited to: dental exam, dental x-rays, extractions, biopsies, tooth-colored and silver fillings, tooth nerve treatments, silver crowns, sealants, cleaning and fluoride, photos for medical documentation.

_______________________________ has discussed with me the information briefly summarized below:

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 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 ____________________________

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

Frm#: YK00142_v4.p10  Rev. Date 02-07-19
PROCEDURE CONSENT

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

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Dilatation 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</td>
<td>Infection, Heavy bleeding requiring blood transfusion, Perforate uterus</td>
</tr>
<tr>
<td>(not necessarily all of them)</td>
<td></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>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Witness Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Translator used: Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

PATIENT INFORMATION

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

Translator used: Yes ☐ No ☐

Translator Signature | Date & Time |
Translator Printed Name | |

Frm#: YK00142_v4.p11 Rev. Date 02-07-19
I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions. I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent. I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.

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

Clinical students may observe:  
[ ] Yes  [ ] No

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

__________________________________________  __________________________________________

__________________________________________  __________________________________________

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

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

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

Clinical students may observe:  
[ ] Yes  [ ] No

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

__________________________________________  __________________________________________

__________________________________________  __________________________________________

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

Frmt: YK00142_v4.p12  Rev. Date 02-07-19
PROCEDURE CONSENT

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

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

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• To collect uterine tissue to help determine the cause of my irregular bleeding.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>• Discomfort, bleeding, infection</td>
</tr>
<tr>
<td></td>
<td>• Injury to the womb</td>
</tr>
<tr>
<td></td>
<td>• Potentially missing an abnormal site.</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>• Missing cancer or precancerous abnormalities of the endometrium</td>
</tr>
<tr>
<td>Alternative Treatments</td>
<td>• Observation without treatment</td>
</tr>
<tr>
<td></td>
<td>• Dilatation &amp; Curettage.</td>
</tr>
</tbody>
</table>

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

Clinical students may observe: ☐ Yes ☐ No

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

Patient is unable to give consent because: ____________________________________________

________________________________________

PATIENT INFORMATION

Name: __________________________
DOB: ________ Med Rec #: _______
DOS: ________ Encounter: _______
Residence: _______________________
Facility: ________________________

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

__________________________ _______________________
Patient Signature Date & Time

__________________________ _______________________
Parent or Guardian Signature Date & Time

__________________________
Printed Name

__________________________ _______________________
Signature of Person Obtaining Consent Date & Time

__________________________
Printed Name

__________________________ _______________________
Witness Signature Date & Time

__________________________
Printed Name

__________________________ _______________________
Translator Signature Date & Time

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

Patient Signature ___________________________ Date & Time 

Parent or Guardian Signature ___________________________ Date and Time 

Printed Name ____________________________________________

Signature of Person Obtaining Consent ___________________________ Date & Time 

Printed Name ____________________________________________

Witness Signature ___________________________ Date & Time 

Printed Name ____________________________________________

Translator used: __ Yes __ No 

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:

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</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

Translator used: [ ] Yes [ ] No

Translator Signature ____________________________ Date & Time

Translator Printed Name

PATIENT INFORMATION

Name: ____________________________

DOB: ________________ Med Rec #: ________________

DOS: ________________ Encounter: ________________

Residence: ____________________________

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

Patient Signature ____________________________ Date & Time ____________________________

Parent or Guardian Signature ____________________________ Date and Time ____________________________

Printed Name

Signature of Person Obtaining Consent ____________________________ Date & Time ____________________________

Printed Name

Witness Signature ____________________________ Date & Time ____________________________

Printed Name

Translator used: Yes ____________________________ No ____________________________

Translator Signature ____________________________ Date & Time ____________________________

Translator Printed Name

---

PROCEDURE CONSENT

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

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

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

Clinical students may observe: Yes ____________________________ No ____________________________

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

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

_______________________________

_______________________________

PATIENT INFORMATION

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

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

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>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 documentation</td>
<td>• Take pieces of tissue if they look suspicious.</td>
</tr>
<tr>
<td></td>
<td>• Give you medicine to make you 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:

________________________________________________________________________________________

________________________________________________________________________________________

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

__________________________________________  __________________________
Patient Signature  Date & Time

__________________________________________  __________________________
Parent or Guardian Signature  Date and Time

__________________________
Printed Name

__________________________________________  __________________________
Signature of Person Obtaining Consent  Date & Time

__________________________
Printed Name

__________________________________________  __________________________
Witness Signature  Date & Time

__________________________
Printed Name

Translator used: 

☐ Yes  ☐ No

__________________________________________  __________________________
Translator Signature  Date & Time

__________________________________________
Translator Printed Name

PATIENT INFORMATION

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

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

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

__________________________ has discussed with me the information briefly summarized below:

### Purpose
- Prevent pregnancy

### Potential Risks (not necessarily all of them)
- Risk of serious pelvic infection resulting in infertility and/or future risk of ectopic pregnancy.
- Risk of painful periods and spotting between periods.
- Risk of uterine perforation.
- Risk of IUD coming out.
- Risk of undesired pregnancy.

### Risks of not having the procedure
- Undesired Pregnancy

### Alternative Treatments
- All other forms of birth control.

---

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

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

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

Clinical students may observe: Yes ☐ No ☐

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

Patient is unable to give consent because:

__________________________

__________________________

---

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

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
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<tr>
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<td></td>
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<td>Date &amp; Time</td>
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<tr>
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<td>Printed Name</td>
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<tr>
<td>Translator used: Yes ☐ No ☐</td>
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<td>Date &amp; Time</td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

---

### PATIENT INFORMATION

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

---

Translator used: Yes ☐ No ☐
Translator Signature: ____________________________  Date & Time
Translator Printed Name: ____________________________
PROCEDURE CONSENT

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

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

_______________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosis of abnormal cervical/womb tissue which could turn into cancer or precancer</td>
<td>• Risk of serious hemorrhage, infection</td>
</tr>
<tr>
<td></td>
<td>• Damage to cervix leading to narrowing of the cervix, cervical incompetence and increased risk of preterm delivery</td>
</tr>
<tr>
<td></td>
<td>• Failure to completely remove abnormal tissue</td>
</tr>
<tr>
<td></td>
<td>• Risk of bowel or bladder injury</td>
</tr>
<tr>
<td></td>
<td>• Reaction to local anesthesia</td>
</tr>
<tr>
<td></td>
<td>• Need for potential blood transfusion if hemorrhage occurs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Progression of abnormal tissue to cervical cancer.</td>
<td>• Observation or referral for cone biopsy or cryotherapy.</td>
</tr>
</tbody>
</table>

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

Clinical students may observe: ☐ Yes ☐ No

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

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

________________________________________________________________________
________________________________________________________________________

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

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</tr>
<tr>
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</tr>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Translator used: ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT INFORMATION**

Name: ______________________________________
DOB: _______________ Med Rec #: ____________
DOS: _______________ Encounter: ____________
Residence: __________________________________
Facility: ____________________________________
I hereby authorize ___________________________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

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

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

________________________________________ has discussed with me the information briefly summarized below:

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

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

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

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

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

Clinical students may observe:  Yes  No

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

*Patient is unable to give consent because:*

________________________________________

________________________________________

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>
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<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
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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>
<tr>
<td>Printed Name</td>
<td></td>
</tr>
<tr>
<td>Translator used:  Yes  No</td>
<td></td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td></td>
</tr>
</tbody>
</table>
PROCEDURE CONSENT

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

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

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

__________________________ has discussed with me the information briefly summarized below:

Purpose • To remove extra teeth.

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

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

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

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

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

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

Clinical students may observe: □ Yes □ No

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>• Moderate / Procedural Sedation in the operating room if necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</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>• To minimize patient's anxiety and pain to allow performance of a procedure</th>
</tr>
</thead>
</table>
| Potential Risks (not necessarily all of them) | • Possible drug reaction  
• Respiratory arrest possibly requiring intubation  
• Hypotension  
• Pneumonia  
• Failure of sedation  
• In extreme rare cases death |

Risks of not having the procedure

| Alternative Treatments | • No Sedation or General Anesthesia |

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

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

Clinical students may observe:  [ ] No

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

__________________________________________

__________________________________________

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

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

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

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

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

__________________________ has discussed with me the information briefly summarized below:

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

Patient Signature ____________________________ Date & Time ____________________________

Parent or Guardian Signature ____________________________ Date and Time ____________________________

Printed Name ____________________________

Signature of Person Obtaining Consent ____________________________ Date & Time ____________________________

Printed Name ____________________________

Witness Signature ____________________________ Date & Time ____________________________

Printed Name ____________________________

Translator used: [ ] Yes [ ] No

Translator Signature ____________________________ Date & Time ____________________________

Translator Printed Name ____________________________

PATIENT INFORMATION

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

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

Technical Description
- Mini-Lap Tubal Ligation

Lay Description
- An incision is made in the lower abdomen to allow access to your tubes.
- A piece will be removed from each tube to prevent future pregnancy.

_________ has discussed with me the information briefly summarized below:

Purpose
- To prevent future pregnancy

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

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

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

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

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

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

Clinical students may observe:  □ Yes  □ No

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

Patient is unable to give consent because:


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

Patient Signature __________________________ Date & Time __________________________

Parent or Guardian Signature __________________________ Date and Time __________________________

Printed Name __________________________

Signature of Person Obtaining Consent __________________________ Date & Time __________________________

Printed Name __________________________

Witness Signature __________________________ Date & Time __________________________

Printed Name __________________________

Translator used:  □ Yes  □ No

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:

- Post Partum Tubal Ligation

Lay Description
- An incision is made beneath the belly button to allow access to your tubes.
- A piece will be removed from each tube to prevent future pregnancy.

______ has discussed with me the information briefly summarized below:

**Purpose**
- To prevent future pregnancy.

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

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

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

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

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Clinical students may observe:  

- ☐ Yes  ☐ No

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

*Patient is unable to give consent because:*

__________________________

__________________________

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

Patient Signature ___________________ Date & Time _______________

Parent or Guardian Signature ___________________ Date and Time _______________

Printed Name ________________________

Signature of Person Obtaining Consent ___________________ Date & Time _______________

Printed Name ________________________

Witness Signature ___________________ Date & Time _______________

Printed Name ________________________

Translator used:  

- ☐ Yes  ☐ No

Translator Signature ___________________ Date & Time _______________

Translator Printed Name ________________________

**PATIENT INFORMATION**

Name: ________________________

DOB: ___________________ Med Rec #: ___________________

DOS: ___________________ Encounter: ___________________

Residence: ___________________

Facility: ___________________
PROCEDURE CONSENT

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

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

__________________________ has discussed with me the information briefly summarized below:

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

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding, infection</td>
<td>Thoracentesis</td>
</tr>
<tr>
<td>Collapsed lung</td>
<td>Thoracentesis</td>
</tr>
<tr>
<td>Need for chest tube.</td>
<td>Thoracentesis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsening or no improvement in breathing</td>
<td>Thoracentesis</td>
</tr>
<tr>
<td>Risk of breathing problems worsening and progressing to suffocation.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not draining fluid and use of pain management and oxygen only.</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>Signature of Person Obtaining Consent</th>
<th>Date &amp; Time</th>
</tr>
</thead>
</table>

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

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</thead>
</table>

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

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

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

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

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

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

PATIENT INFORMATION

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

Translator used: Yes  No

Translator Signature __________________________ Date & Time: __________________________

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

Patient Signature __________________________ Date & Time __________________________

Parent or Guardian Signature __________________________ Date and Time __________________________

Printed Name __________________________

Signature of Person Obtaining Consent __________________________ Date & Time __________________________

Printed Name __________________________

Witness Signature __________________________ Date & Time __________________________

Printed Name __________________________

Translator 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:

__________________________________________

__________________________________________

PATIENT INFORMATION

Name: __________________________

DOB: ______________ Med Rec #: ______________

DOS: ______________ Encounter: __________________________

Residence: __________________________

Facility: __________________________

Translator used: Yes [ ] No [ ]

Translator Signature __________________________ Date & Time __________________________

Translator Printed Name __________________________
**PROCEDURE CONSENT**

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

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>I VP (Excretory Urogram)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Description</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>
<tr>
<td>Questions</td>
<td>Adverse reaction to previous contrast injection:</td>
</tr>
<tr>
<td></td>
<td>Do you have allergies?</td>
</tr>
<tr>
<td></td>
<td>Do you have a history of asthma as a child or as an adult?</td>
</tr>
<tr>
<td></td>
<td>Are you currently taking any of the following?</td>
</tr>
<tr>
<td></td>
<td>Do you have a history of kidney disease?</td>
</tr>
</tbody>
</table>

__________________________ has discussed with me the information briefly summarized below:

**Purpose**

- To look for abnormalities in the G.U. System (Kidney, ureters and bladder)

**Potential Risks**

- Allergic reaction varying degree. i.e. Itching, hives, tightness in the throat, difficulty breathing, renal shut-down, shock, and very rarely death

**Risks of not having the procedure**

- Miss a kidney tumor, cyst. or stone

**Alternative Treatments**

- Ultra Sound, CT — without contrast agent at referral site.

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

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

Clinical students may observe:

- Yes
- No

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

__________________________  
__________________________

**PATIENT INFORMATION**

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

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

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Guardian Signature</td>
<td>Date and Time</td>
</tr>
<tr>
<td>Printed Name</td>
<td>____________________________</td>
</tr>
<tr>
<td>Signature of Person Obtaining Consent</td>
<td>Date &amp; Time</td>
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<tr>
<td>Printed Name</td>
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<td>Witness Signature</td>
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<tr>
<td>Printed Name</td>
<td>____________________________</td>
</tr>
<tr>
<td>Translator used:</td>
<td>Yes</td>
</tr>
<tr>
<td>Translator Signature</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Translator Printed Name</td>
<td>____________________________</td>
</tr>
</tbody>
</table>
PROCEDURE CONSENT

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

Technical Description  •  Outpatient Oral Surgery

Lay Description  •  Outpatient Oral Surgery

_________________________ has discussed with me the information briefly summarized below:

Purpose

- [ ] Control of infection  [ ] relief of pain  [ ] preservation of bone  [ ] relief of crowding/malalignment

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 Signature  __________________________  Date & Time

Parent or Guardian Signature  __________________________  Date and Time

Printed Name

Signature of Person Obtaining Consent  __________________________  Date & Time

Printed Name

Witness Signature  __________________________  Date & Time

Printed Name

Translator used:  [ ] Yes  [ ] No

Translator Signature  __________________________  Date & Time

Translator Printed Name

PATIENT INFORMATION

Name: __________________________

DOB: __________ Med Rec #: __________

DOS: __________ Encounter: __________

Residence: __________________________

Facility: __________________________
**PROCEDURE CONSENT**

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

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

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Potential Risks (not necessarily all of them)</th>
<th>Risks of not having the procedure</th>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prevent pregnancy and periods</td>
<td>• Scarring • Bleeding • Infection • May need extra tests to monitor rod.</td>
<td>• Pregnancy, Heavy periods.</td>
<td>• BCPs, IUD, Depo, Condoms, Etc.</td>
</tr>
</tbody>
</table>

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

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

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

Clinical students may observe: [ ] Yes [ ] No

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

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

______________________________________________________________________________
______________________________________________________________________________

---

**PATIENT INFORMATION**

Name: ________________________________
DOB: ______________________ Med Rec #: ______________________
DOS: ______________________ Encounter: ______________________
Residence: ______________________
Facility: ______________________

---

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

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

---

Translator used:

Yes [ ] No [ ]

---

Facility: ______________________

---

Frm#: YK00142_v4.p30  Rev. Date 02-07-19
I consent to the procedure/operation and sign this of my own free will.

<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>

**Purpose**
- Remove the Implanon rod

**Potential Risks**
- Bleeding
- Infection
- Scar
- Discomfort
- Bruising

**Risks of not having the procedure**
- Implanon will stay in your arm providing birth control

**Alternative Treatments**
- Watching and waiting
- Treating bleeding with birth control pills.

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: ____________________________  Med Rec #: __________

DOB: ____________________________  DOS: ____________________________

Encounter: ____________________________  Residence: ____________________________

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

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

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

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

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

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

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

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

________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________

**PATIENT INFORMATION**

Name: ____________________

DOB: ____________ Med Rec #: ____________

DOS: ____________ Encounter: ____________

Residence: __________________

Facility: __________________

Translator used: □ Yes □ No

Translator Signature | Date & Time

Translator Printed Name

Frm#: YK00142_v4.p32 Rev. Date 02-07-19
PROCEDURE CONSENT
I hereby authorize ____________________________ and such assistants as he/she may designate, to perform the following operation or procedure:

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

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Find the cause of abnormal bleeding</td>
<td>Technical Description</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Risks (not necessarily all of them)</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infection</td>
<td>Technical Description</td>
</tr>
<tr>
<td>• Heavy bleeding requiring blood transfusion</td>
<td>Technical Description</td>
</tr>
<tr>
<td>• Perforate uterus</td>
<td>Technical Description</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risks of not having the procedure</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Infection, bleeding</td>
<td>Technical Description</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
<th>Technical Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication</td>
<td>Technical Description</td>
</tr>
<tr>
<td>• Hysterectomy</td>
<td>Technical Description</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

__________________________

Translator used:  [ ] Yes  [ ] No

__________________________  ____________________________

Translator Signature  Date & Time  Translator Printed Name

PATIENT INFORMATION

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

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

<table>
<thead>
<tr>
<th>Technical Description</th>
<th>Lay Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrous Oxide/Oxygen mixture for labor analgesia</td>
<td>&quot;Laughing Gas&quot; mixed with oxygen</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>Pain relief in labor</td>
<td>Nausea, Vomiting, Dizziness, Drowsiness</td>
<td>Pain of labor</td>
<td>No medication, IV opiates (pain medicine), hydrotherapy (bathtub)</td>
</tr>
</tbody>
</table>

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

Patient Signature ___________________________ Date & Time ___________________________

Parent or Guardian Signature ___________________________ Date and Time ___________________________

Printed Name __________________________________

Signature of Person Obtaining Consent ___________________________ Date & Time ___________________________

Printed Name __________________________________

Witness Signature ___________________________ Date & Time ___________________________

Printed Name __________________________________

Translator used: □ Yes □ No

Translator Signature ___________________________ Date & Time ___________________________

Translator Printed Name ___________________________

PATIENT INFORMATION

Name: ___________________________

DOB: __________ Med Rec #: __________

DOS: __________ Encounter: __________

Residence: ___________________________

Facility: ___________________________
PROCEDURE CONSENT

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

Technical Description • Vasectomy
Lay Description • Remove a piece of each tube which carries sperm

____________________ has discussed with me the information briefly summarized below:

Purpose • Prevent pregnancy in partner

Potential Risks (not necessarily all of them)
• Infection
• Bleeding
• Swelling
• Hematoma
• Failure

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

Alternative Treatments • Various contraceptive methods

I have had an opportunity to discuss my condition, its treatment, and the proposed procedure/operation and to ask questions.
I am satisfied with the explanation I have been given and believe I have sufficient information to give this informed consent.
I accept that this informed consent does not spell out every possible risk or complication. I know that if I do not understand what my doctor has told me, if I have special concerns or want more detailed information, I should ask more questions and get more information before signing this consent agreeing to the procedure/operation.
Clinical students may observe:  [ ] Yes  [ ] No

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

Patient is unable to give consent because:

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

__________________________ Date & Time
Patient Signature

__________________________ Date and Time
Parent or Guardian Signature

__________________________
Printed Name

__________________________ Date & Time
Signature of Person Obtaining Consent

__________________________
Printed Name

__________________________ Date & Time
Witness Signature

__________________________
Printed Name

__________________________ Date & Time
Translator Signature

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

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

__________________________ has discussed with me the information briefly summarized below:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>• Decrease pain and inflammation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential Risks (not necessarily all of them)</td>
<td>• Infection, bleeding, bruising, pain</td>
</tr>
<tr>
<td></td>
<td>• No improvement</td>
</tr>
<tr>
<td>Risks of not having the procedure</td>
<td>• Continued pain</td>
</tr>
<tr>
<td>Alternative Treatments</td>
<td>• Observation</td>
</tr>
<tr>
<td></td>
<td>• Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>• Symptomatic treatment</td>
</tr>
</tbody>
</table>

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

Clinical students may observe:  [ ] Yes  [ ] No

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

* Patient is unable to give consent because:
  ____________________________
  ____________________________

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: ____________________________

Translator used:  [ ] Yes  [ ] No

Translator Signature: ____________________________ Date & Time: ____________________________

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

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

### Birth Control Options

I understand that Essure is a permanent form of birth control (referred to as “sterilization”).

I understand that sterilization must be considered permanent and not reversible.

I was told about other permanent sterilization procedures, such as surgical bilateral tubal ligation (“getting tubes tied”), and their benefits and risks.

I am aware that there are highly effective methods of birth control that are not permanent, and which may allow me to become pregnant when stopped.

Patient Initials ______

### Requirements for Essure Placement and Reliance

I understand that I am not a candidate for Essure if:

- I am uncertain about ending my fertility.
- I have had a tubal ligation procedure (“tubes tied”).
- I cannot have two inserts placed due to my anatomy.
- I am pregnant or suspect that I may be pregnant.
- I have delivered or terminated a pregnancy within the last 6 weeks.
- I have had a pelvic infection within six weeks prior to the date of the scheduled implantation.
- I have a known allergy to contrast dye used during x-ray procedures.

Essure works as intended only when the devices are successfully placed in both fallopian tubes.

I understand that if this is not possible in my case, I may need to undergo a repeat attempt at Essure placement or consider a different form of birth control.

I understand that the placement procedure is only the first step in relying on Essure for birth control.

### After placement:

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

Patient Initials ______

### Patient Information

Name: __________________________________________
DOB: ________________ Med Rec #: ________________
DOS: ________________ Encounter: ________________
Residence: _______________________________________
Facility: _________________________________________

I understand that payment for this test may or may not be covered by my insurance company.

I understand that a satisfactory confirmation test is needed before I can rely on Essure alone. I also understand that after the confirmation test my doctor may inform me that I may not be able to rely on Essure. If this occurs, I will have to use an alternative form of contraception.

I understand that based on clinical studies, approximately 8% of women who undergo attempts at Essure placement are not able to rely on the device for contraception.

Patient Initials ______

### Pregnancy Risks

I understand that no form of birth control is 100% effective. Even if my doctor tells me I am able to rely on Essure, there is still a small chance that I may become pregnant.

Based on clinical studies, the chance of unintended pregnancy for women who have been told they can rely on Essure is less than 1% at 5 years.

I understand that the risks of Essure on a developing fetus have not been established.

If I become pregnant with Essure, there may be an increased risk for the pregnancy to occur outside of the uterus (“ectopic pregnancy”). This may result in serious and even life-threatening complications.

I understand that after Essure placement, I should contact my doctor immediately if I think I may be pregnant.

Patient Initials ______

### What to Expect During the Procedure and the Days Afterwards

I understand that in clinical studies supporting device approval, the following events were reported to occur during the Essure placement procedure and/or in the hours or days following placement:

- Cramping (Reported in up to 30% of procedures)
- Mild to moderate pain (Up to 9–10%) or moderate pain (Up to 13%)
- Nausea/Vomiting (Up to 11%)
- Dizziness/Lightheadedness (Up to 9%)
- Vaginal bleeding (Up to 7%)

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

Patient Initials ______

### Long-Term Risks

I understand that some women may experience continued pain or develop new pain after Essure placement.

I understand that I should contact my doctor if abdominal, pelvic or back pain continues for more than 1 week after placement or if I develop the onset of new pain more than 1 week after placement.

I understand that the Essure implants contain metals including nickel, titanium, iron, chromium, and tin, as well as a material called polyethylene terephthalate (PET).

I understand that some women may develop allergic reactions to the device following implantation and have signs or symptoms such as rash and itching. This may occur even if there is no prior history of sensitivity to those materials. I also understand that there is no reliable test to predict ahead of time who may develop a reaction to the device.
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 ________________________________________

Signature of Witness __________________________ Date & Time __________________________

Printed Name ________________________________________

Translator used: Yes ☐ No ☐

Translator Signature __________________________ Date & Time __________________________

Translator Printed Name ________________________________________

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

Patient is unable to give consent because:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PATIENT INFORMATION

Name: ________________________________________

DOB: __________________ Med Rec #: __________________

DOS: __________________ Encounter: __________________

Residence: ________________________________________

Facility: ________________________________________

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

Patient Signature __________________________ Date & Time __________________________

Parent or Guardian Signature __________________________ Date and Time __________________________

Printed Name ________________________________________

Signature of Person Obtaining Consent __________________________ Date & Time __________________________

Printed Name ________________________________________

Signature of Witness __________________________ 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?  If so, describe: __________________________________________
4. Any history of allergy?  If yes, to what substances are you allergic? ________________
5. Any known allergy to Iodine?  □ Yes □ No

For Technologist (to be performed prior to contrast administration)
☐ Check 2 patient identifiers  □ Perform medicine reconciliation  □ Perform time out
☐ First Dose Review performed by _____________________________________ Title: _____________________________________
☐ Creatinine level (0.6 to <1.3) (If indicated review Contrast Policy)  □ Medication type and Dose __________________________________
☐ Double-checked by: (IV administration only) _________Administered by: __________________________________________

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

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

Clinical students may observe:  □ Yes  □ No

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

Patient Signature  Date & Time

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

Patient, Parent or Guardian Printed Name

Translator used:  Yes  No

Translator Signature  Date & Time

Translator Printed Name

PATIENT INFORMATION

Name: ________________________________
DOB: ________________ Med Rec #: __________________
DOS: ________________ Encounter: __________________
Residence: _______________________________________
Facility: _______________________________________

Consent for Contrast Media
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":
     1. patient’s spouse
     2. 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;
     3. a majority of the patient’s reasonably available adult children;
     4. patient’s parent(s); or
     5. the individual clearly identified to act for the patient (before the patient’s incapacity), the patient’s nearest living relative.

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

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

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

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

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

Attachment B

<table>
<thead>
<tr>
<th>IDENTITY OF PERSON SIGNING</th>
<th>PROOF REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
</tr>
<tr>
<td>&gt; 18/yo + Competent</td>
<td>ID Card or Staff Personally Knows the Patient</td>
</tr>
<tr>
<td>&gt; 16 y/o but &lt; 18 y/o + Emancipated</td>
<td>ID Card &amp; Court Order of Emancipation Marriage Certificate</td>
</tr>
<tr>
<td>&gt; 16 y/o but &lt; 18y/o + Reproductive Health</td>
<td>ID Card and Wishes Reproductive Health Services Records for which there is a Restriction</td>
</tr>
<tr>
<td>Parent of a Minor (Minor = individual &lt; 18 y/o)</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 or Copy of Will</td>
</tr>
<tr>
<td>DFYS or Other Third Party Guardian</td>
<td>ID Card &amp; Court Order of 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>

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