Yukon-Kuskokwim
HEALTH CORPORATION

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.

Contents

Yukon-Kuskokwim HEALTH CORPORATION

Patient Consent Form

PROCEDURE CONSENT

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

Technical Description	
Lay Description	

_____ has discussed with me the information briefly summarized below:

Purpose	
Potential Risks (not necessarily all of them)	
Risks of not having the procedure	
Alternative Treatments	

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

_____ _____
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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Incision and Drainage of Abscess in the OR Consent

PROCEDURE CONSENT

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

Technical Description	• Incision and Drainage of Abscess in the OR
Lay Description	• Cut open and drain the pus out of the boil in the OR

_____ has discussed with me the information briefly summarized below:

Purpose	• Open infected area so it can drain and heal
Potential Risks (not necessarily all of them)	• Pain • bleeding • possible worsening of infection • scar formation
Risks of not having the procedure	• Worsening of infection
Alternative Treatments	• Hot packs and 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.

_____ _____
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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Bilateral Myringotomy with Tubes Consent

PROCEDURE CONSENT

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

Technical Description	• ☐ Right ☐ Left ☐ Bilateral Myringotomy with Insertion of Vented Tubes
Lay Description	• Insert Tubes into the ears

_____ has discussed with me the information briefly summarized below:

Purpose	• To drain fluid from the ears to prevent ear infections and hearing loss.
Potential Risks (not necessarily all of them)	• Bleeding, Infection
Risks of not having the procedure	• Unresolved hearing loss / Draining ears
Alternative Treatments	

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

_____ _____
Patient Signature **Date & Time**

_____ _____
Parent or Guardian Signature **Date 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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Name: _____

DOB: _____ Med Rec #: _____

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Residence: _____

Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Cesearean Section Consent

PROCEDURE CONSENT

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

Technical Description	☐ Primary ☐ Repeat Cesearean Section
Lay Description	• Make an incision in the abdomen and womb to allow surgical delivery of the baby

_____ 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 (not necessarily all of them)	• Pain • Bleeding possibly requiring a blood transfusion • Infection • Perforation of an internal organ which may require transfer to Anchorage for surgery • Cesearian 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:

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

_____ _____
Patient Signature **Date & Time**

_____ _____
Parent or Guardian Signature **Date and Time**

_____
Printed Name

_____ _____
Signature of Person Obtaining Consent **Date & Time**

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Printed Name

_____ _____
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Printed Name

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Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Circumcision Consent

PROCEDURE CONSENT

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

Technical Description	• Circumcision
Lay Description	• Removal of the tip of the skin covering the penis

_____ has discussed with me the information briefly summarized below:

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

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

_____ _____
Patient Signature **Date & Time**

_____ _____
Parent or Guardian Signature **Date and Time**

_____
Printed Name

_____ _____
Signature of Person Obtaining Consent **Date & Time**

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Printed Name

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Witness Signature **Date & Time**

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Yukon-Kuskokwim HEALTH CORPORATION

Colonoscopy Consent

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 medevacced 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

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

_____

_____

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

_____ _____
Patient Signature **Date & Time**

_____ _____
Parent or Guardian Signature **Date and Time**

_____
Printed Name

_____ _____
Signature of Person Obtaining Consent **Date & Time**

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Printed Name

_____ _____
Witness Signature **Date & Time**

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Printed Name

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Translator Signature **Date & Time**

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Translator Printed Name

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DOS: _____ Encounter: _____

Residence: _____

Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Colposcopy Consent

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

_____ has discussed with me the information briefly summarized below:

Purpose	• Looking at the cervix with a magnifying lens and taking a small piece or scraping of any abnormal tissue for further examination looking precancer or cancer
Potential Risks (not necessarily all of them)	• Bleeding, Infection • Missing an abnormal area that exists. • Vaginal discharge.
Risks of not having the procedure	• Failure to diagnose a pre-cancer or cancer that requires treatment.
Alternative Treatments	• Observation without treatment

I 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:

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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**

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Printed Name

Translator used: ☐ Yes ☐ No

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Translator Signature **Date & Time**

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Translator Printed Name

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DOS: _____ Encounter: _____

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Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Cystoscopy Consent

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

_____ has discussed with me the information briefly summarized below:

Purpose	• Rule out bladder tumors or obstruction to urinary flow
Potential Risks (not necessarily all of them)	• Bleeding and infection
Risks of not having the procedure	
Alternative Treatments	• Do nothing

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:

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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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Dental Rehabilitation Consent

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**

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Translator Printed Name

PATIENT INFORMATION

Name: _____

DOB: _____ Med Rec #: _____

DOS: _____ Encounter: _____

Residence: _____

Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Dilation and Curettage Consent

PROCEDURE CONSENT

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

Technical Description	• Dilation and Curettage
Lay Description	• Dilate cervix and empty contents of uterus with suction and scraping out uterus

_____ has discussed with me the information briefly summarized below:

Purpose	• Remove non-living pregnancy to prevent infection and bleeding
Potential Risks (not necessarily all of them)	• Infection • Heavy bleeding requiring blood transfusion • Perforate uterus
Risks of not having the procedure	• Infection, Bleeding
Alternative Treatments	• Waiting for uterus to pass pregnancy on its own

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

Yukon-Kuskokwim HEALTH CORPORATION

Esophagastroduodenoscopy (EGD) Consent

PROCEDURE CONSENT

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

Technical Description	• EGD (esophagogastroduodenoscopy) with possible biopsy and/or polyp removal and possible therapeutic injection • Procedural sedation • Picture taking for medical documentation
Lay Description	• Look in the esophagus, stomach and duodenum with a flexible camera. • Take pieces of tissue, remove growths, and inject medicine if needed to stop bleeding. • Give medications to make you sleepy and more comfortable during the procedure.

_____ has discussed with me the information briefly summarized below:

Purpose	• To examine your esophagus, stomach and duodenum for cancer, polyps (growths), ulcers, bleeding, and infection.
Potential Risks (not necessarily all of them)	• Drug reaction including allergic reaction, low blood pressure, difficulty breathing, and death. • - Bleeding which can occur immediately or later after you are discharged. • Perforation (causing a hole in the esophagus, stomach, and/or duodenum). • Missing an ulcer, growth or cancer. • Inability to complete the procedure requiring additional testing (such as a barium swallow). • If a complication occurs, you might need a blood transfusion, you might need to be hospitalized or medevaced to Anchorage for surgery, and you could possibly die.
Risks of not having the procedure	• Undetected bleeding, ulcers, infection, and cancer resulting in delayed treatment.
Alternative Treatments	• Barium swallow (an X-ray of the esophagus, stomach and duodenum) • No sedation • Medical treatment without endoscopy

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

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

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**

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Printed Name

_____ _____
Signature of Person Obtaining Consent **Date & Time**

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Printed Name

_____ _____
Witness Signature **Date & Time**

_____
Printed Name

Translator used: ☐ Yes ☐ No

_____ _____
Translator Signature **Date & Time**

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Translator Printed Name

PATIENT INFORMATION

Name: _____

DOB: _____ Med Rec #: _____

DOS: _____ Encounter: _____

Residence: _____

Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Endometrial Biopsy Consent

PROCEDURE CONSENT

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

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

_____ has discussed with me the information briefly summarized below:

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

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:

_____

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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**

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Printed Name

_____ _____
Signature of Person Obtaining Consent **Date & Time**

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Printed Name

_____ _____
Witness Signature **Date & Time**

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Translator used: ☐ Yes ☐ No

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Translator Signature **Date & Time**

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Translator Printed Name

PATIENT INFORMATION

Name: _____

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Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Excisional Biopsy Consent

PROCEDURE CONSENT

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

Technical Description	• Excisional Biopsy
Lay Description	• To remove a skin abnormality and/or part of a skin abnormality

_____ has discussed with me the information briefly summarized below:

Purpose	• To remove abnormal growths and/or test tissue for diagnostic purposes
Potential Risks (not necessarily all of them)	• Infection, scarring, • Failure to remove lesion entirely, and re-growth of lesion • Reaction to local anesthetic • Need for wider excision.
Risks of not having the procedure	• Undiagnosed cancer or other tissue abnormalities.
Alternative Treatments	• No Biospy and observation.

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

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

Clinical students may observe: ☐ Yes ☐ No

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

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_____

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**

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Name: _____

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Residence: _____

Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Exercise Stress Test Consent

PROCEDURE CONSENT

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

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

_____ has discussed with me the information briefly summarized below:

Purpose	• To evaluate the ability of your heart to respond to exercise.
Potential Risks (not necessarily all of them)	• In rare cases, such symptoms as abnormal heart rhythms, fainting, heart attacks, and in extremely rare cases, death.
Risks of not having the procedure	• Undiagnosed heart disease with increased risk of death.
Alternative Treatments	

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

Yukon-Kuskokwim HEALTH CORPORATION

External Cephalic Version Consent

PROCEDURE CONSENT

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

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

_____ has discussed with me the information briefly summarized below:

Purpose	• To move the baby into a position which allows a safe vaginal delivery.
Potential Risks (not necessarily all of them)	• Changes in the baby's heart rate which resolve shortly after finishing the procedure • Rupture of the bag of waters and starting labor. • *Very rarely*, severe changes in the baby's heart rate and/or separation of the placenta from the uterus, necessitating an emergency cesarean section.
Risks of not having the procedure	• Cesarean section is the recommended route of delivery for babies that are breech, to prevent serious complications of vaginal delivery such as spinal cord injury.
Alternative Treatments	• Elective cesarean section • Breech vaginal delivery

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Flexible Sigmoidoscopy Consent

PROCEDURE CONSENT

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

Technical Description	• Flexible Sigmoidoscopy with Biopsy with Conscious Sedation • Take pictures for medical documentataion
Lay Description	• Look into rectum and large intestine with a telescope to look for bleeding and cancer • Take pieces of tissue if they look suspicious. • Give you medicine to make your sleepy.

_____ has discussed with me the information briefly summarized below:

Purpose	• To look for cancer and/or bleeding
Potential Risks (not necessarily all of them)	• Bleeding or perforation of colon possibly requiring blood transfusion, transfer to Anchorage for surgery and possibly resulting in death • Possible drug reaction, and/or respiratory arrest. • There is also a risk of missing polyps or cancer
Risks of not having the procedure	• Undetected cancer
Alternative Treatments	• Colonoscopy • Barium Enema

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Placement of IUD Consent

PROCEDURE CONSENT

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

Technical Description	• Placement of IUD
Lay Description	• Put IUD in uterus to prevent pregnancy

_____ 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.

_____ _____
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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Loop Electrical Excision Procedure Consent

PROCEDURE CONSENT

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

Technical Description	• LEEP (Loop Electrical Excision Procedure)
Lay Description	• Cut off a piece of the cervix using an electrical cautery device

_____ has discussed with me the information briefly summarized below:

Purpose	• Diagnosis of abnormal cervical/womb tissue which could turn into cancer or precancer
Potential Risks (not necessarily all of them)	• Risk of serious hemorrhage, infection • Damage to cervix leading to narrowing of the cervix, cervical incompetence and increased risk of preterm delivery • Failure to completely remove abnormal tissue • Risk of bowel or bladder injury • Reaction to local anesthesia • Need for potential blood transfusion if hemorrhage occurs.
Risks of not having the procedure	• Progression of abnormal tissue to cervical cancer.
Alternative Treatments	• Observation or referral for cone biopsy or cryotherapy.

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Lumbar Puncture Consent

PROCEDURE CONSENT

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 (not necessarily all of them)	• 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.

_____ _____
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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Mesiodens Consent

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:

_____

_____

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Moderate / Procedural Sedation Consent

PROCEDURE CONSENT

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

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

_____ has discussed with me the information briefly summarized below:

Purpose	• To minimize patient's anxiety and pain to allow performance of a procedure
Potential Risks (not necessarily all of them)	• Possible drug reaction • Respiratory arrest possibly requiring intubation • Hypotension • Pneumonia • Failure of sedation • In *extreme rare cases* death
Risks of not having the procedure	
Alternative Treatments	• No Sedation or General Anesthesia

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

Yukon-Kuskokwim HEALTH CORPORATION

Laparoscopic Tubal Ligation Consent

PROCEDURE CONSENT

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

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

_____ has discussed with me the information briefly summarized below:

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

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Mini-Lap Tubal Ligation Consent

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:

_____

_____

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

Yukon-Kuskokwim HEALTH CORPORATION

Post Partum Tubal Ligation Consent

PROCEDURE CONSENT

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

Technical Description	• 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 (not necessarily all of them)	• Bleeding, infection • Injury to internal organs • Removal of round ligament & not tube • in 300 risk of pregnancy in future with risk of ectopic if pregnant
Risks of not having the procedure	• Pregnancy & all of its inherent risk
Alternative Treatments	• All other forms of birth control including vasectomy of partner, norplant, depo provera, IUD, oral birth control pills, diaphragm, condoms and foam, sponge, rhythm, and abstinence.

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

Yukon-Kuskokwim HEALTH CORPORATION

Thoracentesis Consent

PROCEDURE CONSENT

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

Technical Description	• Thoracentesis
Lay Description	• Draining lung fluid

_____ has discussed with me the information briefly summarized below:

Purpose	• To drain fluid and air from around lungs • To allow you to breathe better and help diagnose the cause of the problem.
Potential Risks (not necessarily all of them)	• Bleeding, infection • Collapsed lung • Need for chest tube.
Risks of not having the procedure	• Worsening or no improvement in breathing • Risk of breathing problems worsening and progressing to suffocation.
Alternative Treatments	• Not draining fluid and use of pain management and oxygen only.

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Blood Transfusion Consent

PROCEDURE CONSENT

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

Technical Description	• Blood Transfusion
Lay Description	• Blood Transfusion

_____ has discussed with me the information briefly summarized below:

Purpose	• Increasing oxygen in blood needed to support body functions • To help stop bleeding by replacing factors and cells in blood.
Potential Risks (not necessarily all of them)	• Viral Infection, • Hepatitis B • Fever, rash • Hemolytic Reaction • Shortness of breath • Hives • Acquired Immune Deficiency Syndrome (AIDS)
Risks of not having the procedure	
Alternative Treatments	

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

IVP (Excretory Urogram) Consent

PROCEDURE CONSENT

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

Technical Description	• IVP (Excretory Urogram)
Lay Description	• Injection of a special dye (Contrast agent) in a vein to see the fluid collecting system of the kidneys and bladder.
Questions	Adverse reaction to previous contrast injection: ☐ Yes ☐ No Describe:_____ Do you have allergies? _____ Do you have a history of asthma as a child or as an adult? ☐ Yes ☐ No Are you currently taking any of the following? ☐ Metformin ☐ Metaglip ☐ Avandamet ☐ Glucophage ☐ Glucovance. (these medications need to be suspended 24 hours prior to intravenous injection of contrast agent.) Do you have a history of kidney disease? ☐ Yes ☐ No If yes, check BUN/Creatinine levels. Creatinin must be below 2.0

_____ has discussed with me the information briefly summarized below:

Purpose	• To look for abnormalities in the G.U. System (Kidney, ureters and bladder)
Potential Risks (not necessarily all of them)	• 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:

_____

_____

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Outpatient Oral Surgery Consent

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 postoponed to a later date.
Alternative Treatments	• No treatment, restorative, root canal treatement, 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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Implanon Consent Form

PROCEDURE CONSENT

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

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

_____ has discussed with me the information briefly summarized below:

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

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Implanon Removal Consent

PROCEDURE CONSENT

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

Technical Description	• Implanon Removal
Lay Description	• Remove the Implanon rod from your arm by making a small incision and pulling it out.

_____ has discussed with me the information briefly summarized below:

Purpose	• Removethe Implanon rod
Potential Risks (not necessarily all of them)	• 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: _____

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

Yukon-Kuskokwim HEALTH CORPORATION

Anesthesia Consent

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

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

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

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

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

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

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

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

Clinical students may observe: ☐ Yes ☐ No

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

_____

_____

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

_____ _____
Patient Signature **Date & Time**

_____
Printed Name

_____ _____
Signature of Person Obtaining Consent **Date & Time**

_____
Printed Name

_____ _____
Witness Signature **Date & Time**

_____
Printed Name

Translator used: ☐ Yes ☐ No

_____ _____
Translator Signature **Date & Time**

_____
Translator Printed Name

PATIENT INFORMATION

Name: _____

DOB: _____ Med Rec #: _____

DOS: _____ Encounter:_____

Residence:_____

Facility: _____

Yukon-Kuskokwim HEALTH CORPORATION

Diagnostic Hysteroscopy Consent

PROCEDURE CONSENT

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

Technical Description	• Diagnostic Hysteroscopy
Lay Description	• Place a lighted scope in uterus to look at the lining • Dilate cervix and empty contents of uterus, scraping out uterus and cervix

_____ has discussed with me the information briefly summarized below:

Purpose	• Find the cause of abnormal bleeding
Potential Risks (not necessarily all of them)	• Infection • Heavy bleeding requiring blood transfusion • Perforate uterus
Risks of not having the procedure	• Infection, bleeding
Alternative Treatments	• Medication • Hysterectomy

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

Yukon-Kuskokwim HEALTH CORPORATION

OB Nitrous Oxide Consent

PROCEDURE CONSENT

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

Technical Description	• Nitrous Oxide/Oxygen mixture for labor analgesia
Lay Description	• "Laughing Gas" mixed with oxygen

_____ has discussed with me the information briefly summarized below:

Purpose	• Pain relief in labor
Potential Risks (not necessarily all of them)	• Nausea, Vomiting, Dizziness, Drowsiness
Risks of not having the procedure	• Pain of labor
Alternative Treatments	• No medication, IV opiates (pain medicine), hydrotherapy (bathtub)

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Vasectomy Consent

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 • Swellling • 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.

_____ _____
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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Joint Injection Consent

PROCEDURE CONSENT

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

Technical Description	
Lay Description	• Injecting medicine into joint.

_____ has discussed with me the information briefly summarized below:

Purpose	• Decrease pain and inflammation
Potential Risks (not necessarily all of them)	• Infection, bleeding, bruising, pain • No improvement
Risks of not having the procedure	• Continued pain
Alternative Treatments	• Observation • Physical Therapy • Symptomatic treatent

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: _____

Yukon-Kuskokwim HEALTH CORPORATION

Permanent Birth Control ("Essure") Consent

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

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 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.

Continues...

Yukon-Kuskokwim HEALTH CORPORATION

...Continued

Permanent Birth Control ("Essure") Consent

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

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

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

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

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

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

Patient Initials _____

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: _____

Yukon-Kuskokwim
HEALTH CORPORATION
P.O. Box 287 • Bethel, Alaska 99559 • 907-543-6000

Consent for Contrast Media

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

1. Have you had any previous contrast injections? ☐ Yes ☐ No ☐ Unknown
2. If yes, for what kind of study? ☐ IVP ☐ CT ☐ Unknown
3. Any adverse reactions from the injection? ☐ Yes ☐ No
   If so, describe: _____
4. Any history of allergy? ☐ Yes ☐ No
   If yes, to what substances are you allergic? _____
5. Any known allergy to Iodine? ☐ Yes ☐ No
6. Any history of asthma as a child or an adult? ☐ Yes ☐ No
7. Any history of diabetes? ☐ Yes ☐ No
8. If yes, are you taking any meds for diabetes? ☐ Yes ☐ No

If taking any derivative of Metformin, the patient needs to stop taking this medication for 48 hours after the CT exam and follow up with a provider.

8. Any previous history of heart desease (CHF, angina, cardiomyopathy)? ☐ Yes ☐ No
9. Any history of kidney disease, renal insufficiency or surgery to the kidneys? ☐ Yes ☐ No

Females only:

10. Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
11. Are you breastfeeding? ☐ Yes ☐ No

For Technologist (to be performed prior to contrast administration)

☐ Check 2 patient identifiers ☐ Perform medicine reconciliation ☐ Perform time out

☐ First Dose Review performed by _____ Title: _____

☐ Creatinine level (0.6 to <1.3) (If indicated review Contrast Policy) ☐ Medication type and Dose _____

☐ Double-checked by: (IV administration only) _____ Administered by: _____

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

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

Clinical students may observe: ☐ Yes ☐ No

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**

_____
Pateint, Parent or Guardian 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: _____

POLICY: Patient Consent for Treatment	POLICY NUMBER: ADM_037_CL
CATEGORY: Administration	EFFECTIVE DATE: July, 2003
SECTION: Clinical	SUPERSEDES: New

I. POLICY:

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

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

II. PURPOSE:

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

III. DEFINITION:

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

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

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

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

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

1. The patient's diagnosis.

2. The general nature of the contemplated procedure, its purpose, whether it is experimental, and the name(s) of the person(s) who will perform the procedure or administer or direct the treatment.

3. The benefits, risks, discomforts, and complications associated with the procedure, recuperation that may reasonably be expected, including all risks of the procedure or treatment, the likelihood of success.

4. The patient's prognosis if the procedure is not performed.

5. Reasonable alternative medical treatments, if any.

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

1. Oral consent – Consent conveyed through speech.

2. Written consent – Consent conveyed through written documentation. There are two types of Written Consent: (1) General Written Consent for Diagnosis and Treatment, and (2) Written Consent for Specific Medical and Surgical Procedures.

F. Implied Consent: Consent that may be inferred by the patient's behavior (e.g., a patient extending his arm for blood to be drawn). Implied consent is rarely documented and may be relied upon only for care or treatment that is routine and does not involve significant risk(s). Implied consent may not be relied on for HIV testing.

IV. PROCEDURE:

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

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

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

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

Standard reference: JCAHO (TX.)
Written by: Vivian Lee, Chief Nurse Executive

Committee signature: Health Services Team

Approval signature _____

Attachment A
MSEC Approved Consents

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

Attachment B

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

(Footnotes)

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