INFORMED CONSENT FOR SURGERY, TREATMENT, DIAGNOSTIC PROCEDURE, AND USE OF SEDATION OR ANESTHESIA, EMERGENCY USE OF BLOOD

I hereby authorize _____ (name of physician/medical staff provider) and/or such associates or assistants as he/she may select to treat: (name of patient) _____ for the following condition(s) requiring treatment: _____

_____

_____

☐ Surgical or other procedure(s) _____

_____

_____

_____

Check one box (site: ☐ right ☐ left ☐ both ☐ n/a)

RISKS, BENEFITS AND ALTERNATIVES I understand the patient's condition and what the treatment or procedure described above is supposed to do and how it will help the condition. I have been told that the treatment may not work. I understand that if there are complications or if unexpected conditions are found, other procedures may be needed. I consent to those procedures if there is no time to talk to me. I have been told about the risks (what might go wrong), other treatment choices, and what might happen if the treatment is not done. Common risks to surgical procedures include bleeding, infection, failure of the procedure to work, and possible need for further surgery. In addition, the following risks specific to this procedure have been discussed with me and include: _____

_____

_____

_____

ANESTHESIA, SEDATION AND ANALGESIA I consent to the administration of anesthesia or sedation, if applicable. I have been made aware that complications of anesthesia or deep sedation are rare, but may include cardiac arrest (heart stoppage), brain damage, or death. Complications of moderate sedation include nausea, agitation, and allergic reactions to the medicine. Also, if the child becomes deeply sedated, there can be difficulty breathing and loss of oxygen to the brain. If I have any questions, I am aware that I may call an anesthesiologist at (202) 476-2025.

BLOOD/BLOOD PRODUCTS I also authorize the emergency treatment of this patient with blood/blood products, if medically necessary. If this procedure is expected to require blood I understand I will sign a separate blood consent along with this surgical consent. I understand that my child's/my physician/medical staff provider will discuss with me the likelihood of the need for blood/blood products prior to this procedure. I understand that this consent will be valid for emergency blood/blood product administration in the operating room and recovery room only; should blood/blood products be required after transfer out of the recovery room I will be asked to sign a separate blood consent form. I also understand that if blood/blood products are needed during the procedure or in the recovery room there may not be time for the physician to tell me before blood/blood products are administered.

CONSENT

I have read, been informed, and understand the above and any attached information, and what my child's/my doctors/medical staff providers have told me about risks, benefits and alternatives or options. I have been given the chance to ask questions. I consent to the procedures or treatments listed, and to the use of anesthesia/sedation. By signing below I certify that I am legally authorized to give consent on behalf of this patient. I understand that if I decide to revoke my consent, I must do so prior to the beginning of the procedure by asking for this form back and completing the revocation portion below.

Signature	Print Name	Date
Telephone Number		Time
Witness Signature	Date	Time

Relationship of consenting person to the patient:

☐ Parent ☐ Guardian (attach copy of court order)
☐ Public Agency (acceptable by fax w/o witness) ☐ Person with written authorization (attach)
☐ Patient: (☐ 18 years or older ☐ consenting for self for certain procedures ☐ emancipated minor)
☐ Other (see consent policy) _____

SPECIAL CONSENT CIRCUMSTANCES

☐ The above was read to the consenting person ☐ Read to the consenting person using an interpreter in _____ (indicate language) ☐ The above information was discussed by telephone with the consenting person by the physician signing below. (Print name and telephone number of consenting person and indicate relationship above)

PHYSICIAN CONFIRMATION

I informed the consenting party of the condition requiring treatment, and have, consistent with my best medical judgment, explained the nature, purposes, risks, benefits and complications of the proposed procedure, any alternatives, administration of blood or blood products and the contents of this form. The person giving consent has repeated back to me a correct understanding of the above detailed information.

M.D. / Medical Staff Provider	Date	Time

VERIFICATION OF PROCEDURE AND SITE IMMEDIATELY PRIOR TO INCISION OR START OF PROCEDURE Verified by: _____Date: _____ Time: _____

EMERGENCY CONSENT This patient's medical condition requires immediate treatment and does not allow for informed consent by the patient/legal guardian. In my medical judgment, a delay in the procedure or treatment will be harmful to the patient. Signature: _____, M.D./D.O. Signature:_____, M.D./D.O.
Print: _____, M.D./D.O. Print:_____, M.D./D.O.
Date_____ Time:_____ Date:_____ Time:_____

REVOCATION OF CONSENT: I hereby revoke my consent to the above procedure.

Name	Signature	Date	Time

Physician/Medical Staff Provider certification: I verify that on _____ date at ____ time, I was informed by the parent/guardian of _____(child's name) that consent for this procedure has been revoked.

Name	Signature	Date	Time

Informed consent July 2014
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