St. Charles
HEALTH SYSTEM

Patient Label

PATIENT INFORMED CONSENT

Name of Patient: _____

Name of Person Signing this Form and Relationship to Patient: _____

Name of Physician or licensed health care practitioner ("Practitioner"): _____

Surgery / Procedure / Treatment ("Treatment"): _____

_____

_____

_____

Site: _____ Side: ☐ Right ☐ Left ☐ N/A

1. I authorize the Practitioner named above to perform the Treatment listed above. The Practitioner has given me a general description of the Treatment, and has explained to me, in a way I understand, that there may be other possible treatments, including the option of obtaining a second opinion from a different health care provider, and that there are risks to the Treatment. The Practitioner has asked me whether I want more detailed explanation, and if I requested it, the Practitioner has told me in more detail about the Treatment, the available alternatives and the risks.
   I understand that all medical treatment has some risk. I understand that in addition to bleeding, infection, injury to surrounding organs, and death, there are particular risks associated with this Treatment, and that other complications may occur. I have discussed with the Practitioner these risks to my satisfaction, and have also discussed the risks of not proceeding with the Treatment.
2. I understand that during the Treatment, unanticipated conditions may be discovered that require a change to the Treatment plan, or a different Treatment than is named above. I authorize the Practitioner to perform any additional or more complicated procedures that, in the Practitioner's judgment, are necessary for my benefit. I understand that the Practitioner will follow St. Charles policies and may ask people whom I have designated or whom the law designates to make decisions on my behalf.
3. I understand that a blood transfusion, including cell-saver blood or blood products, may be required during or after the Treatment. The risks of receiving these blood products have been explained to me, and include allergic reactions, contracting a blood borne disease, as well as other risks, including death. **I consent to receive the blood products that the Practitioner believes are medically necessary for me**. If I do not consent to receiving blood products, I understand that I will be asked to sign a Refusal of Blood Transfusion Form.
4. I understand that other Practitioners, nurses, assistants, staff, residents, and students may participate in my care, and may complete important tasks related to the Treatment, consistent with their scope of practice and St. Charles' policies and, in the case of residents or students, based on their skills and under the supervision of the responsible Practitioner. I understand that the Practitioner, the Anesthesiologist or Certified Registered Nurse Anesthetist, or other health care providers participating in my care may not be employees or agents of St. Charles, and that St. Charles is not legally responsible for their acts or omissions.

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5. If the Treatment requires moderate sedation, including other types of minimal or local anesthesia or pain numbing, I consent to administration of such sedation by my Practitioner or other qualified person. I have been informed how moderate sedation is performed. I understand that sedation medications involve risks of decreased breathing, changes to heart rate and blood pressure, inhalation of stomach contents into your lungs, nausea and vomiting, unpleasant memories of the experience, injury to teeth, mouth and / or eyes, and other more serious complications, up to, and including death.
6. If the Treatment requires general anesthesia, I understand that the Anesthesiologist or Certified Registered Nurse Anesthetist will explain the risks, benefits, alternatives, of such general anesthesia and will separately obtain my consent.
7. If the Treatment requires multiple subsequent treatments and procedures as specifically described by my Practitioner, then by initialing here _____ and signing this form, I hereby consent that this single consent is valid and may be relied upon for each subsequent related Treatment, without the need to separately obtain further consent(s). This section is known as a 'serial consent,' and will have no force or effect unless initialed by the patient or patient's legal representative. If initialed and signed, this serial consent remains in effect unless revoked in writing, provided that hospitalization that is unrelated to the Treatment will require execution of a separate informed consent form.
8. I consent to the presence of manufacturers' representatives during the Treatment. In the interest of medical education, I consent to the presence of observers in the operating room during the Treatment.
9. I authorize St. Charles to dispose any tissues or medical devices removed from me during Treatment.
10. I consent to the taking of pictures, videos, or other electronic reproductions ("Photos") of me during Treatment, and to the use of such Photos for treatment or internal or external activities consistent with St. Charles' policies.

ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. NO WARRANTY OR GUARANTEE WAS MADE BY ANY HEALTH CARE PROVIDER AS TO ANY PARTICULAR RESULT OR CURE. I HAVE INFORMED THE PRACTITIONER ABOUT MY SIGNIFICANT MEDICAL CONDITIONS, INCLUDING WHETHER I MAY BE PREGNANT. I HAVE READ THIS FORM IN ITS ENTIRETY, AND UNDERSTAND AND AGREE WITH ITS CONTENTS.

BY SIGNING BELOW, I GIVE MY INFORMED CONSENT TO THE TREATMENT AND APPROVE ALL OTHER MATTERS DESCRIBED ABOVE (approval for serial consent is valid only if initialed above).

Signature of Patient or Patient's Legal Representative ***(Required)***	*Relationship*	*Date*	*Time*
Witness to Signature of Patient or Patient's Legal Representative ***(Required)***	☐ *Check if telephone consent*	*Date*	*Time*
Signature of Practitioner obtaining patient's informed consent ***(Required)***		*Date*	*Time*
**Emergency Waiver of Consent. All attempts to reach an authorized surrogate of the patient have been unsuccessful. In my professional judgment, immediate treatment is necessary to preserve life or prevent serious impairment to health.* *Signature of Practitioner* _____		*Date*	*Time*