St. Charles
HEALTH SYSTEM

Patient Label

PATIENT PROCEDURAL INFORMED CONSENT

SIGN ONLY AFTER READING THE WHOLE FORM CAREFULLY AND DISCUSSING YOUR TREATMENT PLANS WITH YOUR DOCTOR

Name of Patient: _____

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

Name of Physician, Physician Assistant, or Nurse Practitioner ("Doctor"): _____

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

_____

_____

_____

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

1. I authorize my Doctor to perform the Treatment listed above. The Doctor 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 doctor or provider, and that there are risks to the Treatment. The Doctor has asked me whether I want more detailed explanation, and if I requested it, the Doctor 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 these risks with the Doctor to my satisfaction. I have also discussed with the Doctor 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 Doctor to perform any additional or more complicated procedures that, in the Doctor's judgment, are necessary for my benefit. I understand that the Doctor 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 reactions, getting a disease, and other risks, including death. I consent to receive the blood products that the Doctor believes are medically necessary for me, or, **by initialing here, _____ (initial) I indicate that I give my consent to the use of blood or blood products.** If I do not initial above, I understand that I will be asked to sign a Refusal of Blood Transfusion Form.

* 3 C O N T X *

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4. I understand that Doctors, nurses, assistants, staff, residents, and students may participate in my care, and may complete important tasks related to the Treatment, consistent with 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 Doctor, 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.

5. I understand that the Treatment may require moderate sedation, or other types of anesthesia or pain numbing, and which may be given to me by a nurse.

6. 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.

7. I authorize St. Charles to dispose of any tissues or medical devices which are removed from me during Treatment.

8. 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 DOCTOR 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.

I GIVE MY PERMISSION AND INFORMED CONSENT TO THE TREATMENT DESCRIBED ABOVE.

Signature of Patient or Authorized Patient Representative ***(Required)***	*Relationship*	*Date*	*Time*
Witness to Signature of Patient or Authorized Patient Representative ***(Required)***	☐ *Check if telephone consent*	*Date*	*Time*
Signature of Physician, Physician Assistant, or Nurse 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 Doctor or Physician Assistant or Nurse Practitioner* _____		*Date*	*Time*