Verification of Consent and Authorization for Surgery, Obstetrical, Special Diagnostic, or Therapeutic Procedures

1. ____
(Name of Patient)

2. Your physician or surgeon is ______________________________, M.D.

____, M.D.

3. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other specific diagnostic and therapeutic procedures. These operations and procedures may all involve risks or unsuccessful results, complications, injury or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

4. You have the right to be informed by your physician of the risks as well as the nature and purpose of the operation or procedure and the available alternative methods of treatment and this form is not a substitute for such explanations which are provided by the above named physicians. Except in cases of emergency, operations or procedures are not performed until the patient has had the opportunity to receive such explanations. You have the right to consent or to refuse any proposed operation or procedure.

5. Your physicians and surgeons have recommended the operations or procedures set forth below. Upon your authorization and consent, such operations or procedures, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency or previously unforeseen circumstances, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above or his designee together with associates and assistants, including anesthesiologists, pathologists, radiologists and other hospital based physicians from the medical staff of this hospital to whom the supervising physician or surgeon may assign designated responsibilities.

   Your physician(s) or surgeon(s) have recommended the following operation or procedure(s):

   ____

   ____

   ____

   ____

6. Your anesthesiologist or surgeon will select the type of anesthesia to be used in your operation or procedure, and will educate you on the risks and benefits of anesthesia.

7. **Your physicians and surgeons and the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the hospital but are independent contractors and, therefore, are your agents, servants or employees.**

8. To make sure that you fully understand the operation or procedure(s), your physician will fully explain the operation or procedure(s) to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.

9. The pathologist, physician, surgeon or hospital are hereby authorized to use his/her/its/their discretion in disposing of or retaining any member, organ, foreign body or other tissue or body fluid removed from my person during the named procedure, any of which and its/their related medical information may be used for teaching, study, and research purposes, including the development of potentially commercial useful products, except: ____

____.

10. Medical and nursing students or other observers or product vendors may be admitted to the operating room in accordance with the practices of this hospital. Closed-circuit television may be used, photographs (including motion picture) taken, and drawings and similar illustrative graphic material prepared with the understanding that such materials are to be used for instructional, medical or other scientific purposes only.

11. If your physician determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure or medical condition requiring blood or blood products to which you are consenting, your physician will inform you of this and will provide you with a brochure regarding blood transfusions. This brochure contains information concerning the benefits and risks of the various options for blood transfusions, including predonation by yourself or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait. You should understand that transfusions of blood or blood products involve certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV) and that you have a right to consent or refuse consent to any blood transfusion. You should also discuss any questions that you may have about blood transfusions with your physician.

12. YOUR SIGNATURE BELOW CONSTITUTES YOUR ACKNOWLEDGMENT AND VERIFICATION THAT:

(A) YOU HAVE READ AND UNDERSTAND ALL OF THE INFORMATION PROVIDED ON ALL SIDES OF THIS FORM;

(B) THE OPERATION OR PROCEDURES SET FORTH ON THIS FORM HAVE BEEN ADEQUATELY EXPLAINED TO YOU BY YOUR PHYSICIAN OR SURGEON;

(C) YOU HAVE HAD A CHANCE TO ASK QUESTIONS;

(D) YOU UNDERSTAND THAT THERE ARE RISKS AND HAZARDS ASSOCIATED WITH THE OPERATION OR PROCEDURE(S) AND ANESTHESIA;

(E) YOU HAVE RECEIVED ALL OF THE INFORMATION YOU DESIRE CONCERNING THE OPERATION OR PROCEDURE(S);

(F) YOU AUTHORIZE AND CONSENT TO THE PERFORMANCE OF THE OPERATION OR PROCEDURE(S) OR BLOOD TRANSFUSION(S) AS INDICATED ON THIS FORM; AND

(G) YOU HAVE GIVEN SPECIAL INSTRUCTIONS TO YOUR PHYSICIAN, SURGEON, AND THE HOSPITAL IN THE EVENT YOU HAVE REFUSED BLOOD TRANSFUSION.

DATE	**PATIENT/PARENT/LEGAL GUARDIAN** (If signed by other than patient, indicate relationship below)
TIME	RELATIONSHIP
WITNESS #1	WITNESS #2 (For Telephone Consent)

Patient unable to sign because: ____

13. Interpreter's verification: I declare that I have read to the patient and/or if appropriate his/her representative the entire contents of this document in the ____________________ language, which the patient had requested to be used.

______________________________ ______________________________

DATE AND TIME SIGNATURE OF INTERPRETER

14. Consent to Transfusion of Blood or Blood Products

In accordance with the **Paul Gann Blood Safety Act**, your signature below indicates that:

(A) You have received a copy of the brochure entitled, A Patient's Guide to Blood Transfusions;

(B) You have received information concerning the risks and benefits of blood transfusions and any alternative therapies;

(C) You have had the opportunity to discuss this matter with your physician, including predonation;

(D) Subject to any special instructions listed below, you consent to such blood transfusions as your physician may order in connection with the operation or procedure described in this consent form.

Special Instructions: ____

____

____

(Describe here any specific instructions for patient's blood transfusions, e.g., predonation, directed donation, refusal of blood transfusion, etc.)

______________________________ ______________________________

DATE **PATIENT/PARENT/LEGAL GUARDIAN**
(If signed by other than patient, indicate relationship below)

______________________________ ______________________________

TIME RELATIONSHIP

______________________________ ______________________________

WITNESS #1 WITNESS #2 (For Telephone Consent)

Patient unable to sign because: ______________________________

15. PHYSICIAN'S DOCUMENTATION OF INFORMED CONSENT AND PROCEDURE SITE:

I am the patient's physician, surgeon or health practitioner. I have discussed the following with the patient or decision maker: 1) the nature of the procedure(s); 2) the risks, benefits, potential complications of the procedure(s) and any alternatives including not having the procedure(s); 3) the risks and potential complications of not having the procedure(s) performed; 4) any unique concerns known to me; and 5) any conflicts. I have provided an opportunity for the patient or the decision maker to ask questions and have provided answers to those questions according to my education, training, skills and professional opinion. The patient or the decision maker has considered all the information provided, and elected to have the procedure(s) performed.

I have reviewed the consent form and find the procedure(s) and site(s) accurate for this patient at this time.

If the patient has consented to transfusion of blood or blood products, I have provided the patient with a copy of the State Department of Health Services Information Pamphlet, A Patient's Guide to Blood Transfusions, Concerning the Advantages, Disadvantages, Risks and Benefits of Autologous Blood and of Directed and Non-Directed Homologous Blood from Volunteers. I have also allowed adequate time prior to surgery for the patient or other person to predonate blood for transfusion purposes, except where there is a life threatening emergency, there are medical contraindications, or the patient has waived this right.

______________________________ ______________________________

Date Physician/Surgeon, Health Practitioner

Circle One: MD PA NP

RULES GOVERNING CONSENT

1. Adults: Consent of patient is sufficient for own surgery procedure if the patient has medical decision-making capability and is 18 years of age or over. Exception: Procedure involving sterilization requires separate sterilization consent form.
2. Married Minors: Minors who currently are or who have ever been married (i.e. minors who are married, divorced or widowed) may give informed consent, and the consent of the parent(s) or guardian is not required.
3. Unmarried Minors: Consent must be signed by one parent, or the legally appointed guardian. Consent of the patient if 15 years of age and over, is desirable but not required.
    A. Consent of unmarried pregnant minor is sufficient for own surgery and procedures related to pregnancy.
    B. Consent of an unmarried minor is sufficient if the minor is serving on active duty with any of the armed services of the United States.
    C. For self-sufficient minors (i.e. those who live separate and apart from the minor's parent(s) or guardian, manage his or her own financial affairs and are at least 15 years of age) please refer to the California Health Care Association Consent Manual for direction.
4. Investigation Of Child Abuse: A physician may order x-rays of a minor without the consent of the minor's parent(s) or guardian for purposes of diagnosing possible child abuse and determining the extent of such abuse. Consent of parent or guardian is required to provide other treatment.
5. Suspected Sexual Abuse: A minor who is alleged to have been sexually assaulted or abused may give consent to diagnosis and treatment of the abuse without the consent of the minor's parent(s) or guardian. However, the practitioner providing treatment must attempt to contact the minor's parent(s) or guardian and document the date and time of attempted contact and whether the contact attempt was successful. Contact need not be attempted if the practitioner believes that the minor's parent or guardian committed the sexual abuse.
6. Wards of the Court: Consent must be signed by a parent. Consent of judge is required only when one parent's consent is unobtainable. For wards on probation the probation officer's consent is acceptable. For children relinquished to the department of adoptions, the casework director, assistant casework director and district director are authorized to consent. The consent of a foster parent is acceptable only upon the written authorization of the authorizing agency.
7. Telephone Consents: Two nurses must listen to a verbal consent received by telephone. Both must then witness the consent and date and time the consent form. As soon as possible afterward a written consent must be completed. A telegram sent by the next of kin, parent or guardian is acceptable as a legal consent when these authorized persons are not present to sign the consent form.
8. Emergency or Unobtainable Consent: In the case of an emergency in which consent is unobtainable from the patient or patient's legal representative, the treating physician must document on the patient's medical record the nature of the emergency and the treatment or procedure which is required to alleviate severe pain or to diagnose or treat medical conditions which could lead to serious disability or death if not immediately diagnosed and treated.