CONSENT FOR SURGICAL AND PROCEDURAL TREATMENT

(DIAGNOSTIC & SURGICAL PROCEDURES & OTHER INVASIVE PROCEDURES)

The law in Washington gives you the right and the responsibility to make decisions about your health care. Health care professionals can give you information and advice. You or your legal representative must be part of the decision-making. This consent form:

- Proves that you had a part in making decisions about your health care.
- Shows that you gave permission for the treatment recommended by your health care professionals.

The words "I", "my", etc., in this form mean the patient, no matter whether the patient or the patient's representative is signing the form. The term "health care professional" may mean the attending physician, but in addition may mean a different doctor (including a resident), nurse practitioner, or physician's assistant, who orders, performs all or part of, or is involved in explaining the procedure.

I give permission to my health care professional(s) who are listed on the back of this form as the performing provider(s), to do the procedure(s) listed on the back of this form, with anesthesia and/or sedation if that is needed. Anesthesia or sedation medicine will be given by the health care professional, anesthesiologist, or other trained health care staff who work under appropriate supervision.

I understand that the attending physician may need to perform other urgent procedures due to an emergency that may occur while I am sedated or otherwise not able to give consent. The attending physician or designee will talk with my legally authorized representative if possible.

I understand that the attending physician may choose assistants, including other health care professionals and residents *(physicians who have finished medical school, but are getting more training)*, to be part of the team performing my procedure. The assistants may suture; harvest grafts; dissect, remove or alter tissue; implant devices; or do other tasks that the attending physician has deemed appropriate. If known, the attending physician has discussed with me whether there will be assistants and whom s/he expects the assistants to be. I understand that during the procedure, the attending physician may need to choose different assistants or have them do different tasks. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be there, doing things like providing consultation or running checks on the equipment.

I understand the attending physician may participate in care involving overlapping procedures or oversee other urgent medical responsibilities and may not be present in the room at all times. During this time, the skilled team of assistants may perform portions of my procedure which the attending physician has determined they are proficient to perform. The attending physician will be present for the key and critical portions of the procedure, and either he/she or a designated attending physician will be available to the procedure team at all times.

The hospital or health care professional will dispose of any removed tissues or parts.

I understand what procedure(s) will be done. I have been told about the risks and benefits. I have been told about other treatment choices and about their risks and benefits, including not having the procedure. I have been told about what results to expect, which includes information about the chances for the expected results. I know that results cannot be guaranteed. I have been told about potential problems that may occur during recuperation.

I understand that there are risks for all kinds of surgery and for "invasive procedures" *(procedures where a blood vessel, body cavity, or other internal tissue is entered with a needle, tube, or similar device)*. These risks, which can be serious, include bleeding, infection, and damage to nearby tissues, vessels, nerves, or organs. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I have received this added detailed information and/or patient information materials about the procedure(s):

_____

_____

Print added information or title of information materials

I understand whether I will receive either general anesthesia or sedation medicine, or both**.** I have been told about my choices for anesthesia and sedation and about their risks and benefits. I have been told about side effects of the medicine(s) and problems they may cause with recovery.

I understand that anesthesia and sedation medicines used for procedures involve risks. These risks can be serious. They may include damage to vital organs such as the brain, heart, lungs, liver, and kidneys. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I understand that the anesthesia equipment may damage my teeth or cause other dental damage.

I understand that nerve damage may occur from how anesthesia equipment is placed or how my body must be positioned during a procedure.

I understand that I am free to refuse consent to any proposed procedure.

Continued on Reverse

PLACE PATIENT LABEL HERE

860350
CONTENT LAST APPROVED OCT 23

BLOOD: A blood transfusion may be required during or immediately after the procedure(s) (while the patient is in the procedure room and/or recovery). Risks of transfusion include transfusion reaction and/or infection. I consent to receive blood or blood products as deemed necessary.

OR *(Please initial)*

_____ **I refuse *(or partially refuse)* permission for blood and blood components.** I understand I have the right to refuse the use of blood products. This may significantly decrease the ability of my healthcare team to care for me in the event of an emergent and life-threatening condition. I understand every effort is made to prevent the spread of infection and match blood products. My Provider has answered all of my current questions related to this issue, and has informed me of the risks associated with deciding to refuse blood products. I understand if I have additional questions that would assist me in making an informed decision regarding the safety and use of modern blood products, I can ask my healthcare team/provider at any time. Notwithstanding the risks we have discussed, I have made the informed decision to REFUSE blood products at this time.

☐ **Interpreter** ***(Print Name)*** _____ ID # _____

Giving Consent

By signing below, I confirm that I have read the sections above and that I have had 1) each item explained to me; 2) a chance to ask questions; and 3) all of my questions answered.

FULL NAME OF PROCEDURE(S)	
Health Care Professional(s) Performing Procedure	

SIGNATURE ***(PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)***	**PRINT NAME**	**DATE**	**TIME**

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

- ☐ **1.** Court-appointed Guardian
- ☐ **2.** Durable Healthcare Power of Attorney
- ☐ **3.** Spouse/registered domestic partner
- ☐ **4.** Adult Child(ren)
- ☐ **5.** Parent(s)
- ☐ **6.** Adult Brother(s)/Sister(s)
- ☐ **7**. Adult Grandchild(ren)
- ☐ **8**. Adult Niece(s)/Nephew(s)
- ☐ **9**. Adult Aunt(s)/Uncle(s)
- ☐ **10**. Adult Friend with executed Declaration per RCW 7.70.065

FOR MINOR PATIENTS:

- ☐ **1.** Guardian/legal custodian
- ☐ **2.** Court-authorized person for child in out-of-home placement
- ☐ **3.** Parent(s)
- ☐ **4.** Holder of signed authorization from parent(s)
- ☐ **5.** Adult representing self to be a relative responsible for the minor's health

WITNESS SIGNATURE *(WITNESS OPTIONAL UNLESS TELEPHONE CONSENT)*	PRINT NAME	☐ TELEPHONE MONITORED CONSENT *(No patient signature)*

Note *This consent is valid for 30 days. If there has been a change in the patient's condition or procedure performed, please use a new consent.*

HEALTH CARE PROFESSIONAL'S STATEMENT: I explained the treatment/procedure(s) stated on this form, including the possible risks, complications, alternative treatments *(including non-treatment)* and anticipated results to the patient and/or his/her representative before the patient and/or his/her representative consented. If only the patient has signed this form, in my clinical opinion, the patient is capable of making his/her own health care decisions. If in my clinical opinion, the *(adult)* patient has questionable ability to make his/her own health care decisions, I discussed the above with the patient and with the patient's legally authorized representative.

HEALTH CARE PROFESSIONAL SIGNATURE	PRINT NAME & TITLE	NPI *(IF APPLICABLE)*	DATE	TIME

PLACE PATIENT LABEL HERE