# VERIFICATION OF INFORMED CONSENT FOR TREATMENT

Dr. _____ and I [print patient's name]: _____

agree that I will have [name of procedure(s)]: _____

_____

The reason for this is: [patient's medical condition]: _____

This will be done or supervised by Dr. _____

At: [name of hospital or clinic]: _____

**A. I have had a chance to talk with the doctor about the procedure:**

- What it is and what it involves.
- How it may help me (benefits).
- The most likely and serious ways it might harm me (risks).
- The possible long-term effects.
- Other choices for treatment and their risks and benefits.
- What will probably happen if I say no.
- How I might feel right away afterward and how quickly I am expected to recover.
- What medicines I may need, including some that may control my pain and others may sedate me or make me sleepy.

**B. I agree:**

- To ask questions.
- No one has guaranteed me the outcome of this procedure.
- Students and others approved by the facility may watch the procedure.
- Pictures or video may be taken of the procedure. They will be used only for medical purposes.
- The facility may examine and respectfully dispose of tissues or things removed from my body. They won't be used for research without my permission or sold.
- I can change my mind and not have the procedure any time before it begins.
- My doctor may have help from others. Help might include things like opening and closing the wound, taking grafts, cutting out tissue, implanting devices, and other important things. My doctor has told me who they are, if he or she knows, and has answered questions I may have about them.
- My doctor may fix serious things that were not known in advance if my doctor thinks it is in my best interest.

**C. Blood and blood products.** My doctor has discussed with me whether I may need blood transfusions and the risks, benefits, and alternatives to transfusions. ☐ **Yes** ☐ **No**

I agree that I may be given blood (or blood products) in connection with the procedure and for the rest of my hospital stay: ☐ **Yes** ☐ **No**

**D. Blood tests.** I agree that the hospital or clinic may test my blood for HIV and hepatitis if a healthcare worker is accidentally exposed to my blood or body fluids during the procedure. The results of the test will go in my medical record and will be given to:

- The worker so he or she can decide whether immediate treatment is needed;
- The facility's Employee Health Services and/or Infection Control Department; and, if the test is positive,

***I have had my questions answered. I agree (consent) to the procedure described above.***

*I have written any exceptions or limits to my agreement here:* _____

_____

_____ _____ _____

Patient (or Representative) Signature | Date | Time

Patient representative's relationship to patient: _____

***I have discussed the procedure and the information stated above with the patient (or patient's representative) and answered their questions. The patient or representative consented to the procedure.***

_____ _____ _____

Physician or Provider Signature(s) | Date | Time

***I have verified that the patient has signed this form before the procedure.***

_____ _____ _____

Witness | Date | Time

(PATIENT LABEL)