

Kadlec Medical Center  
888 Swift Blvd  
Richland, WA 99352  
(509) 946-4611

Patient Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_

PATIENT IDENTIFICATION

**INFORMED CONSENT FOR PROCEDURAL TREATMENT  
(DIAGNOSTIC & SURGICAL PROCEDURES, ANESTHESIA & OTHER PROCEDURES)**

Washington State law gives patients the right and the responsibility to make decisions about their health care. Doctors can give you information and advice, but the patient (or his/her "legally authorized representative") must be part of the decision making. This form confirms permission for treatment recommended by the patient's doctor.

**NO ABBREVIATIONS ARE ALLOWED ON THIS CONSENT FORM**

**This procedure is to be performed at Kadlec Medical Center.**

I give permission to Dr. \_\_\_\_\_ to perform \_\_\_\_\_  
*Print Attending Doctor Name* *Full Name of Procedure(s)*

on *(Print Patient's Name)* \_\_\_\_\_

with the anesthesia and/or sedation as may be thought necessary, to be given by my/the patient's doctor, by an anesthesiologist, or other trained health care professional under a doctor's direction.

**I have had the following things explained to me, and I have had a chance to ask questions and to have my questions answered:**

1. The kind of procedure(s) to be performed. This includes anesthesia/sedation and/or other medicines.
2. The expected results of the procedure(s) (including anesthesia/sedation), and the general chance of having the results happen. **I understand** that results cannot be guaranteed.
3. Possible other forms of treatment, including not having the procedure(s), and including other choices about anesthesia/sedation.
4. Expected benefits of the procedure(s) and of the possible other forms of treatment.
5. Serious possible risks and complications of the procedure(s) (including anesthesia/sedation), and of the possible other forms of treatment. This includes side effects from medicines and problems with recovery.  
\***I understand** that there are some general risks for all types 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 surrounding tissues, vessels, nerves, or organs.  
\***I understand** that all anesthetics involve risks of complications and possible serious damage to vital organs such as the brain, heart, lung liver and kidney. In some cases, these may result in paralysis, cardiac arrest and/or brain death. I understand that dental damage may occur as a risk of anesthesia. I understand that nerve damage may occur as a risk of surgical/anesthesia positioning.
6. I have received a patient information packet for (if applicable): \_\_\_\_\_

**Patient may cross out and initial any paragraph below that he/she does not agree to.**

**I understand** that any surgeon, anesthesiologist, radiologist, and/or pathologist involved in my care at Kadlec Medical Center are members of the hospital medical staff. These physicians are not employed by nor are they agents of the hospital.

**I consent to the administration of blood and blood products** if my doctor thinks this is necessary. I understand that all blood and blood products involve risk of allergic reaction, fever, hives, and in rare circumstances infectious diseases such as hepatitis and HIV/AIDS. I understand that precautions are taken by the hospital's licensed supplier of blood and blood products, the American Red Cross, in screening donors and in matching blood for transfusion to minimize those risks. **If I do not want to receive blood (or blood products), I have discussed this with my doctor and am enrolled in Kadlec's Bloodless Medicine program.**

**I understand** that the hospital will study, retain or dispose of any tissues or parts surgically removed during my procedure.



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**Special Consent for Procedural Treatment, (Diagnostic & Surgical Procedures, Anesthesia & Other Procedures)**

**Patient may cross out and initial any paragraph below that he/she does not agree to.**

If I have an **Advanced Directive**, I have discussed this with my physician. I agree that my Advanced Directive will be suspended during my procedure/surgery and during my immediate post-operative/procedure care unless expressly stated otherwise and agreed upon.

**I understand** that medical/surgical procedure photographs or video may be taken by my physician during the course of my surgery or procedure. I understand that these are the property of the hospital and a copy may be retained by my physician. All attempts will be made not to include personally identifiable images.

**I agree** to the admittance of observers and healthcare students to the Operating or Procedure Room for the purpose of advancing medical education. I agree that individuals receiving medical training may be involved in my care under the direct supervision of my physician. I also agree to the admittance of manufacturers' representatives and/or contracted technicians to the room during my procedure for the purpose of observing and/or for technical support during the operation of equipment that may be utilized.

**I understand** that closed circuit monitoring is used within the operating suites for patient safety and staff efficiencies. No audio or videotapes are made or maintained.

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**PHYSICIAN'S STATEMENT:** The surgery or procedure stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results, were explained by me to the patient or his/her representative before the patient or his/her representative consented.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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**FULL DISCLOSURE:** I certify that my physician has informed me of the nature and character of the proposed treatment/surgery, of the anticipated results of the proposed treatment/surgery and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and in the alternative forms of treatment, including non-treatment.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient/Other Legally Responsible Person Signature

Relationship of Legally Responsible Person to Patient:  Spouse  Child  Sibling  Legal Guardian  \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness

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**LIMITED DISCLOSURE:** I have requested limited disclosure of the above and do not wish to have these risks and facts explained to me.

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient/Other Legally Responsible Person Signature

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness

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**INTERPRETER'S DECLARATION:** I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the physician.

Interpreter's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Telephone consents must be witnessed by two (2) staff members. Be sure to indicate name of person consenting.