CHRISTIANA CARE
HEALTH SERVICES

CNSNT

Date of procedure: _____/_____/_____

Patient name:

Date of birth:

CONSENT FOR PROCEDURE

Instructions:
1. Complete either side 1 or side 2.
2. **Draw a single line through the side that does not apply.**

Side 1

I,_____, request and give consent to _____
(Type or print patient name) (Type or print doctor or practitioner name(s))

to perform the following procedure(s) _____
(Please list site and side if appropriate)

_____

_____

The benefits, risks, complications, and alternatives to the above procedure(s) have been explained to me.

I understand that the procedure(s) will be performed at Christiana Care by and under supervision of my doctor or practitioner. My doctor or practitioner may use the services of other doctors or practitioners, or members of the resident staff as he or she deems necessary or advisable.

I authorize my doctor or practitioner and his or her associates and assistants to perform such additional procedures, which in their judgment are necessary and appropriate to carry out my diagnosis or treatment.

I authorize the hospital to retain, photograph, preserve and use for scientific, teaching purposes, or to make other dispositions of, at their convenience, any specimens, tissues, or parts taken from my body during the course of this operation.

I consent to observers in the procedure area in accordance with hospital policy. I consent to a healthcare industry representative being present during the procedure, if necessary, to provide technical assistance or to perform calibration of equipment. I consent to photography or video taping of my surgical procedure for educational purposes, provided my identity remains anonymous and confidential.

I consent to the administration of sedation or analgesia during my procedure. The risks, benefits, and alternatives to receiving sedation or analgesia have been explained to me.

If anesthesia is required, I consent to the administration of anesthesia by members of the Department of Anesthesiology. I also consent to the use of non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in addition to those resulting from the operation itself including, but not limited to, dental injury, hoarseness, vocal cord injury, infection, nerve injury, corneal abrasion, seizures, heart attack, stroke and even death.

If applicable, I consent to the use of fluoroscopy. I understand that prolonged exposure to fluoroscopy may result in skin reactions, such as redness, irritation or a burn.

Please initial one of the following statements (females 55 years and under):

_____To the best of my knowledge I am not pregnant. _____I believe I am pregnant.

I certify that I have read and understand the above consent statements. In addition, I have been offered the opportunity to ask my doctor or practitioner any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s).

_____ ___/___/___ _____ _____ ___/___/___ _____
Signature of Patient or Decision Maker Date Time Doctor or Practitioner Signature/Title Date Time

_____ _____
Relationship to Patient Doctor or Practitioner Print Name or ID#

_____ ___/___/___ _____
Witness Signature Date Time

_____
Witness Print Name

Telephone Consent:

_____ _____
Name of person providing consent Relationship to Patient if Decision Maker

_____ ___/___/___ _____ _____ ___/___/___ _____
Witness Signature Date Time Witness Signature Date Time

_____ _____
Witness Print Name Witness Print Name

Interpretation: The information presented orally to the ☐ patient ☐ representative ☐ decision maker was interpreted into (language): _____. The person for whom the information was interpreted stated s/he understood the interpretation.

_____ _____
Interpreter Name Agency and ID# (if applicable)

_____ _____ ___/___/___ _____
Staff Signature/Title Print Name or ID# Date Time