Patient Identification Label

USA HEALTH Hospitals

VERIFICATION OF CONSENT

for

Surgery, Special Procedure, Blood Administration

We help people lead longer, better lives.

University Hospital

I or my designee _____ Consent to have performed on me this procedure:
(Name of Patient)

Closed Reduction and Splinting of Fracture and/or Dislocation

(Write out procedure to be performed)

and any additional procedures the practitioner deems necessary or advisable during the course of this procedure. ☐ Initials

This procedure will be performed by: _____
and his/her designated assistants whose roles will be directly supervised for all critical parts of the procedure. ☐ Initials

Anesthesia/Sedation: I consent to the administration of anesthetics and drugs as may be considered necessary or advisable for this procedure, and the risks and benefits as explained to me. ☐ Initials

Photography/Videography: I consent to having this procedure(s) photographed/videoed, including portions of my body that are appropriate for medical, scientific or educational purposes, providing my identity is not revealed by the pictures or by the descriptive texts accompanying them. ☐ Initials

Blood or Blood Product Transfusion

Blood Transfusions: I consent to the administration of blood or blood products to stabilize my condition, save my life, or promote my recovery. ☐ Initials

Blood Transfusion REFUSAL: I refuse blood and blood product transfusions.

USA Health Hospitals Verification of Understanding

Disclosure of Information: I understand that the hospital and physician are required by Federal Law to disclose my demographic information including my social security number to the manufacturer of any implanted device.

Education: I understand that my procedure may be observed by students and/or manufacturer representatives as requested by the surgeon or anesthesiologist.

Patient/Practitioner Discussion: The practitioner has explained the diagnosis, proposed procedure, purpose of proposed treatment/procedure, possible risks and benefits of the proposed treatment/procedure, possible alternatives to proposed treatment/procedure, and possible risks of not receiving the treatment/procedure.

Verification of Consent: I have read and fully understand this Verification of Consent form. I understand that signing this Verification of Consent form indicates the risks/benefits/alternatives of the planned treatment/procedure have been explained to me and my questions have been answered to my satisfaction. I understand that I may withdraw consent at any time before the beginning of the treatment/procedure. I understand no promises or guarantees have been made concerning the outcome or results of the planned treatment/procedure and I wish to proceed.

Patient/Legally Responsible Person Signature	Date	Time	(Relationship if other than patient)
Verified by Clinical Staff Member Signature	Date	Time	(Print Name)
2nd Witness (Phone Consent Only)	Date	Time	(Print Name)

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USA HEALTH HOSPITALS

Physician Documentation of Informed Consent Discussion

Patient Name: **DOB:**

DATE	TIME	Informed Consent discussion may be documented below, in Progress Notes, H&P, or in office notes if included in the patient's hospital medical record.
		Diagnosis:
		Proposed Procedure: ***Closed reduction***
		Discussed the need for recurrent procedures: ***Yes***
		Purpose of proposed treatment/procedure: ***Place misaligned and broken bones in correct anatomical position***
		Possible risks and benefits of proposed treatment/procedure: ***Benefit-Relief of pain and improvement in function*** ***Risk-Nerve injury, failure to align bones, swelling, blood vessel injury***
		Possible alternatives to proposed treatment/procedure: ***Observation***
		Possible risks of not receiving treatment/procedure: ***Delay in treatment and possible resulting disability,*** ***Chronic pain***
		Physician Signature: