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) |

Patient Identification Label

# 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:**<br>***Yes*** |
| | | **Purpose of proposed treatment/procedure:**<br>***Place misaligned and broken bones in correct anatomical position*** |
| | | **Possible risks and benefits of proposed treatment/procedure:**<br>***Benefit-Relief of pain and improvement in function***<br>***Risk-Nerve injury, failure to align bones, swelling, blood vessel injury*** |
| | | |
| | | |
| | | **Possible alternatives to proposed treatment/procedure:**<br>***Observation*** |
| | | **Possible risks of not receiving treatment/procedure:**<br>***Delay in treatment and possible resulting disability,***<br>***Chronic pain*** |
| | | **Physician Signature:** |