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)

Nerve Block

(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:
		Discussed the need for recurrent procedures: ***Yes***
		Purpose of proposed treatment/procedure: ***Regional anesthesia, pain reduction***
		Possible risks and benefits of proposed treatment/procedure: ***Risks: Bleeding, infection, damage to nearby structures nerve damage, permanent anesthesia*** ***Benefits: Aid in treatment and/or diagnosis of condition, pain reduction, facilitate procedures***
		Possible alternatives to proposed treatment/procedure: ***Systemic analgesia, no analgesia or anesthesia***
		Possible risks of not receiving treatment/procedure: ***Increased pain, inability to tolerate procedures***
		Physician Signature:

Revised 6/22