MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

☐ Hale Ho'ola Hamakua
☐ Ka'u Hospital

Consent for Operative Care, Medical Treatment, Anesthesia, Procedural Sedation, or Other Procedure

Date of Procedure:

Valid for 30 days from patient signature date

You have the right and obligation to make decisions concerning your healthcare. Your physician can provide you with the necessary information and advice, but because this affects you, you must enter into the decision-making process. This form has been designed to document your decision about treatment recommended by your physician. Please feel free to ask any questions.

I hereby authorize Dr. _____ and any associate or assistant _____ involved in my care to treat/ diagnose the following CONDITION(s) which has (have) been explained to me.

MEDICAL LANGUAGE: _____

_____

ORDINARY / LAY LANGUAGE: _____

_____

The PROCEDURE(s) planned for my treatment of my condition(s) has (have) been explained to me by my physician as follows:

MEDICAL LANGUAGE: _____

_____

ORDINARY / LAY LANGUAGE: _____

_____

(Explain the nature of the condition(s) in professional and lay language).

- At this facility, during the course of the operation, postoperative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may require my above named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life or bodily functions.
- I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.
- No promise or guarantee has been made to me as to result or cure.

Any sections below, which do not apply to the proposed treatment, may be crossed out. Both physician and patient must initial all sections crossed out.

- If I need anesthesia my anesthesiologist or nurse anesthetist is responsible to inform me of the plan, risks, benefits and alternatives.
- I consent to the administration of anesthesia (general, spinal, regional, and/or local) or procedural sedation by my attending physician, an anesthesiologist, a nurse anesthetist, or other qualified party (under the direction of a physician) as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney. These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.
- Any tissues or part surgically removed may be disposed of by the hospital or physician in accordance with customary practice.
- I consent to the photographing, video monitoring or other media of the operation or procedure to be performed, including appropriate portions of my body, for the internal purpose of performance improvement, provided that my identity is not revealed by the picture or by descriptive text accompanying them.
- I consent to the observation of the operative procedure for the purpose of advancing medical education.

Any additional comments may be inserted here: _____

_____

BLOOD PRODUCT CONSENT ON REVERSE

FULL DISCLOSURE

I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF:

a. My diagnosis or probable diagnosis.
b. The nature of the proposed care, treatment, services, interventions, medications, and procedures.
c. The potential benefits, risks or side effects, including problems related to recuperation.
d. The likelihood of achieving care, treatment, and service goals.
e. The reasonable alternatives to the proposed care, treatment and services.
f. The relevant risks, benefits, and side effects related to alternatives.
g. Any limitations on the confidentiality of information learned from or about me.

_____

Patient/Legal Rep. Signature Date Time

Relationship (if not self):
☐Parent of Minor ☐ DPOAH ☐ Guardian ☐ Surrogate
☐Other _____

_____

Witness Signature Date Time

_____

Physician Signature Date Time

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Consent for Blood or Blood Products

Valid for Current Acute Hospitalization or Annually in Long Term Care

I was given full opportunity to ask questions and my questions were all addressed to my satisfaction. By signing below, I acknowledge that my doctor provided an explanation of the following:

- The condition being treated.
- The nature and character of the proposed blood / blood product.
- The name of the physician or other practitioner who has primary responsibility for my care.
- Anticipated results and benefits, risks, including problems related to recuperation, and recognized serious possible risks, and complications, and the likelihood of success of the proposed transfusion.
- Anticipated benefit(s) may include increased oxygenation, prevention of active bleeding or stopping of abnormal bleeding, maintenance of blood pressure, improvements of blood flow, prevention of infection, and/or sustaining of life.
- Recognized possible alternative(s) to transfusion, and anticipated results and benefits, including problems related to recuperation, and recognized serious possible risks and complications, and the likelihood of success of the possible alternative(s).
- Not performing the transfusion and anticipated results, benefits, recognized possible side effects, serious risk(s), and complications; includes but not limited to fever, rash, headache, blood transfusion reactions or very rare side effects such as contracting hepatitis or HIV/AIDS and death.
- This authorization is valid for the duration of your admission and/or course of treatment, which requires repeated outpatient blood product administration.
- This authorization may be revoked in writing or verbally by the patient or authorized patient representative at any time.

Acceptance of Blood Products: I understand and agree that no guarantee or warranty applies to the blood or blood products. I further understand fully that no guarantee or assurance has been made as to the results that may be obtained from receiving blood products.

Patient/Legal Rep. Signature Date Time

Relationship (if not self):
☐Parent of Minor ☐ DPOAH ☐ Guardian ☐ Surrogate
☐Other _____

Witness Signature Date Time

I have discussed with and explained to the patient the risks, benefits and alternatives for blood and blood products and the patient verbalizes understanding. (Note: Physician signature required as soon as practical)

Physician Signature Date Time

Refusal of Blood Products: I am aware of the benefits and risks of: 1) receiving blood and or blood products (transfusion); 2) alternatives to transfusion; and 3) not receiving a transfusion, and it is my decision to REFUSE this treatment.

Patient/Legal Rep. Signature Date Time

Relationship (if not self):
☐Parent of Minor ☐ DPOAH ☐ Guardian ☐ Surrogate
☐Other _____

Witness Signature Date Time

PROCEDURE CONSENT ON REVERSE