Alaska Native Medical Center

CONSENT FOR ADMINISTRATION OF ANESTHESIA AND
FOR PERFORMANCE OF OPERATIONS OR OTHER PROCEDURES

* C S P *

PATIENT: I ☐ DO ☐ DO NOT wish the services of a translator.

1. DIAGNOSIS (medical terminology): Blood count abnormality

   DIAGNOSIS (common terminology): _____

2. OPERATION OR PROCEDURE (medical terminology): Bone Marrow Biopsy +/-Aspirate

   OPERATION OR PROCEDURE (common terminology): Remove solid and liquid bone marrow from hip

   Benefits of the operation or procedure are: Make diagnosis

   Common risks and complications of the procedure are: Bleeding, infection, pain, nerve injury

   There may be unknown complications that have not been identified to date.

   Possible alternatives to the procedure and/or anesthesia are: No biopsy

3. PATIENT CONSENT *(Line through any parts that are refused by the patient.)*

   A. *I hereby give my consent and authorize* _____ *of ANMC to perform the above named operation or other procedure. All my questions have been answered to my satisfaction. I acknowledge that no promises or guarantees have been made to me as to the results that may be obtained.*
   (Name of Provider(s))

   B. *I consent to the performance of the operation or procedure and any emergent operations or procedures that are found to be necessary in the best judgment of the medical staff during the planned operation or procedure.*

   C. *I consent to the administration of anesthesia that is considered necessary in the judgment of the medical staff.*

   D. *I consent to the disposal by ANMC of any body tissues or parts which may be necessary to remove in accordance with applicable laws and regulations. I authorize the facility to retain, preserve and use for scientific or teaching proposes any tissue or specimens taken from my body.*

   E. *I consent to the admittance or participation of observers, vendors or supervised students in accordance with the policies and procedures of the ANMC.*

   F. *I understand that photographs and movies may be taken of this operation or procedure which may be viewed by personnel undergoing training at this or other facilities. I consent to the viewing of such movies and photographs for scientific or educational purposes, provided my identity is not revealed by the pictures or written information accompanying them.*

4. COUNSELING PROVIDER: I have counseled this patient as to the nature of his/her condition, the proposed proeedure, the risks, alternatives and expected results.

   Signature of Provider Securing Consent: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

   Signature of Provider Securing Consent: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

5. PATIENT: I understand the diagnosis, the proposed operation or procedure, its risks and the alternatives, and the expected results.

   Patient's Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

   Witness's Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

6. IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:

   ☐ Patient is a minor OR ☐ Is unable to sign due to : _____

   I, _____ (Write in parent name or patient's representative), _____ (Write in relationship to patient) of _____ (Write in patient name), understand the nature of the patient's condition, the proposed procedure, the benefits, the risks and the alternatives, and the expected results.

   Parent/Patient's Rep Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

   Witness's Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

   ☐ CONSENT OBTAINED BY TELEPHONE. Contact name and phone #: _____

7. TRANSLATOR: I, _____ (print name), have translated the information presented to the person giving this consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge he/she understands this explanation.

   Trauslator's Signature:_____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

PATIENT IDENTIFICATION

Time Out Required Elements

1. Correct patient name and birth date, 2. Correct Procedure, 3. Correct site/side marked

Procedure _____ Time Out Verifier_____
Date:_____ Time:_____ AM ☐ PM ☐ or _____Military

Procedure _____ Time Out Verifier_____
Date:_____ Time:_____ AM ☐ PM ☐ or _____Military

** Operating Room Time Out is documented electronically**
Radiology will complete Time Out when applicable

Alaska Native Medical Center

INFORMED CONSENT for BLOOD PRODUCTS TRANSFUSION

* C S P *

1. I have been informed that in the course of my medical treatment, I may need blood and/or one of its products. Blood products include whole blood, red blood cells, fresh frozen plasma, platelets, cryoprecipitate, autologous or intra-operative salvaged autologous blood.

2. I understand that there are risks associated with this therapy even though all donors are carefully screened by medical history and their blood has been tested by laboratory analysis. This analysis includes but is not limited to testing for unexpected antibodies, hepatitis B, antibody to HIV (exposure to the virus causing AIDS), and syphilis. I understand that these measures cannot completely eliminate the risk of possible infection or unfavorable body reaction to the introduction of foreign and infectious agents that have not been identified by scientists and therefore cannot be detected.

3. My doctor has described the known common risks associated with blood products transfusions including those risks listed below. The risks and consequences of not receiving this therapy have also been explained, as have the alternatives to include the use of my own blood (autologous), donated before surgery and if applicable, intra-operative salvaged autologous blood.

ADVERSE EFFECT *	FREQUENCY
Infected by:	
HEPATITIS A	1 in 10 million units
HEPATITIS B	1 in 800,000 to 1 in 1.2 million units
HEPATITIS C	1 in 1.15 million units
HIV** (Type 1 & 2)	1 in 1.5 million units
Human T-cell Lymphotrophic Virus (I & II)	1 in 641,000 units
Cytomegalovirus (CMV)	<1% (Most adults not susceptible)
Other: (Malaria, Syphilis, T. Cruzi and Babesiosis)	1 in ≥ 1 million units
Bacterial Contamination:	
Platelet Sepsis	1 in 83,000 units
RBC Sepsis	1 in 5 Million units
Noninfectious Risks of Transfusion	
Allergic (Uticaria)	1 in 250 units
Febrile Non-Hemolytic Reaction	1 in 500 units
Transfusion Related Acute Lung Injury (TRALI)	1 in 2,000 to 1 in 5,000 units
Delayed Hemolytic Reaction	1 in 4,000 to 1 in 12,000 units
Transfusion Associated Circulatory Overload	1 in 7,000 to 1 in 15,000 units
Acute Hemolytic Reaction	1 in 12,000 units
ABO Incompatible Transfusion	1 in 38,000 units
Anaphylactic Reaction	1 in 150,000 units

* These and other adverse effects (e.g., embolism, clotting, chemical imbalanec, etc.) may also occur with my own blood transfusions (autologous/intraoperative blood salvage).

Data is from the references below:

1) Transfusion Therapy: Clinical Principles and Practice, 3rd Edition AABB Press 2011.

2) Guidelines for Blood Recovery and Reinfusion in Surgery and Trauma, AABB 2010.

3) AABB Technical Manual, 18th Edition AABB Press 2014

Updated Blood Utilization Review 11/2015

OTHER RISKS (to be completed by provider if indicated)

4. I have read (or had read to me) and I understand the above information on blood products transfusion. I have had the opportunity to ask questions and my questions were answered. I hereby consent to blood products transfusion(s) as explained to me.

Provider Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

Patient/ Patient's Representative Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

Witness's Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

☐ **CONSENT OBTAINED BY TELEPHONE.** Contact name and phone # _____

5. TRANSLATOR: I, _____ (print name), have translated the information presented to the person giving this consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge he/she understands this explanation.

Translator's Signature:_____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

6. ☐ REFUSAL OF BLOOD PRODUCTS TRANSFUSION

I have read (or had read to me) and I understand the foregoing information on blood products transfusion, including the risks associated with not receiving a transfusion if medically indicated.
I have had the opportunity to ask questions and my questions were answered to my satisfaction.
I hereby do not consent to blood products transfusion(s).

Provider Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

Patient/ Patient's-Representative Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

Witness's Signature: _____ **Date:**_____ **Time:**_____ **AM ☐ PM ☐ or** _____**Military**

PATIENT IDENTIFICATION