CONSENT FORM FOR CASE REPORTS

For a patient's consent to publication of information about them in a journal or thesis

Name of person described in article: Melinda Evensvold

Subject matter of article: Hepatology

Title of article: An Unusual Case Report of Abdominal Pain with Hepatomegaly

Medical practitioner or corresponding author: Catherine T. Frenette

I [redacted] give my consent for this information about MYSELF Melinda Evensvold, relating to the subject matter above ("the information") to appear in a journal article, or to be used for the purpose of a thesis or presentation.

I understand the following:

1. The information will be published without my name/child's name/relatives name attached and every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - perhaps, for example, somebody who looked after me/my child/relative, if I was in hospital, or a relative - may identify me.
2. The information may be published in a journal which is read worldwide or an online journal. Journals are aimed mainly at health care professionals but may be seen by many non-doctors, including journalists.
3. The information may be placed on a website.
4. I can withdraw my consent at any time before online publication, but once the information has been committed to publication it will not be possible to withdraw the consent.

Signed: [redacted] Date: [redacted]

Signature of requesting medical practitioner/health care worker:

[redacted] Date: [redacted]

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VALIDATION OF PRE-PROCEDURAL INSTRUCTIONS

[redacted]
MRN[redacted] DOB:[redacted] F/50
07/14/15 CHR ACCT:614762938
CHANDRA, ANKUR MD
SCRIPPS GREEN HOSPITAL, LA JOLLA

My procedure has been explained to me. I have carried out the following:

1. I have had nothing to eat or drink since midnight the day prior to my procedure.

2. I have made arrangements for my transportation home. I have been advised that I am not to drive an automobile, operate machinery, drink alcohol or make important personal decisions for the next 24 hours.

3. I have made arrangements for a responsible adult to be with me overnight for a 24 hour period.

4. I understand that if in the event of unforeseen circumstances I am not sufficiently recovered to be discharged from Out Patient Surgery arrangements will be made to admit me to the hospital for overnight observation.

[redacted]
Witness

7/14/15
Date and Time

[redacted]
Patient

Patient's Parent, Agent or Representative

Relationship to Patient

1CNT

315-7100-000 (3/17/09)

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[redacted] F/50
07/14/15 GHR ACCT:814762938
CHANDRA, ANKUR MD
SCRIPPS GREEN HOSPITAL, LA JOLLA

CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES

6. I authorize [redacted] M.D./D.O. and/or associates or assistants of his or her choice and personnel assigned by the facility to perform the following operation or procedure upon me:

[redacted]

☐ With Moderate Sedation

and/or to do any other procedures that in his/her judgment may be indicated due to any emergency. I understand that the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the facility or my supervising physician or surgeon. They are independent contractors and, therefore, are my agents, servants, or employees.

7. Patients with breast cancer diagnosis and treatment: I acknowledge that the physician named above has provided me with "A Woman's Guide to Breast Cancer Diagnosis and Treatment". _____ (patient to initial, if applicable).

8. My signature on this form indicates that: (1) I have read and understand the information provided in this form, (2) the operation or procedure set forth above has been adequately explained to me by my physician, (3) I have had an opportunity to ask questions, (4) I have received all of the information I desire concerning the operation or procedure, and (5) I authorize and consent to the performance of the operation or procedure.

SIGNATURE:

[redacted] 0720 7/14/15 AM / PM
Patient / Legal Representative Printed Name Date/Time

[redacted] AM / PM
Signature of Witness Printed Name Date/Time

Patient physically unable to sign, reason: _____

Interpreter: _____ AM / PM
ID Code or Signature / Printed Name Date/Time

3CNT