INFORMED CONSENT FORM

PART A *Completed for any procedure requiring written Informed Consent including blood or blood products*

1 I have talked to my doctor or health care practitioner about

a What the procedure/treatment is and what will happen
b How it may help me (the benefits)
c How it may harm me (the most likely and most serious risks)
d The long term effects the procedure may have
e My other choices for treatment and the risks and benefits of those choices
f What will likely happen if I say no to this procedure
g How I may feel right after and how quickly I can expect to recover
h What medicines will be used to manage pain or sedate me
i The likelihood that the procedure will help me meet my treatment goal

2 I agree that (If I do not agree with a statement I have crossed it out and initialed next to it)

a I will ask questions
b Students and others may watch the procedure after approval by this facility
c If it is best for me my doctor/health care practitioner may change the plan if other serious problems are found during the procedure
d Pictures or video may be taken to be used for medical educational or quality reasons only

3 I understand that

a No one has promised me definite results
b I can change my mind If I do I must tell my doctor or health care practitioner as soon as possible
c The team will double check who I am They will ask what I am having done This is to protect me
d If a staff person is exposed to my blood or body fluids my blood will be drawn and tested for HIV and hepatitis The test results will go to me in my medical record to the Employee Health Services Department and/or Infection Control at this facility to state health officials and to the exposed worker this is to decide if treatment for the worker is needed
e Tissues or items removed from my body may be tested They will be disposed of with respect Unless I check the box below leftover tissue not needed for my care may be used for research or teaching purposes

☐ No I do not agree that my tissue can be used for research or teaching purposes

4 The following written Informed Consent Supplement(s) (ICS) have been discussed with me

☐ None ☐ Blood Management ☐ Anesthesia _____
Anesthesia Provider Signature (optional) *Date/Time*

☐ Other _____

PART B *Must be completed if the patient is undergoing a procedure with general/regional anesthesia moderate/deep sedation or Monitored Anesthesia Care (MAC) and is optional for all other procedures*

5 Blood Transfusion

☒ Yes you may give me blood (blood products) if I need them during my stay I have been told how likely it is that I will need a blood transfusion I know the risks benefits and alternatives of receiving blood (blood products) My special instructions about blood products are listed in Part C

☐ No you may not give me blood (blood products) for any reason I have been told how likely it is that I will need a blood transfusion I know the risks benefits and alternatives of receiving blood (blood products)

☐ *N/A Not applicable*

6 Code Status If I have Do Not Resuscitate (DNR) wishes Full Code

☐ You may suspend my DNR wishes during the procedure and immediate post anesthesia period
☐ I want my DNR wishes to continue during the procedure and immediate post anesthesia period
☐ I want my Partial Code order as outlined in my medical record to be followed during the procedure and immediate post anesthesia period
☒ *N/A – Not applicable the patient is full code*

Allina Health
ABBOTT NORTHWESTERN HOSPITAL

[redacted]

PART C *Completed for any procedure requiring written Informed Consent*

I [print patient s name] [redacted]

a Agree that I will have [state the planned procedure/treatment]
Ultrasound guided random liver Biopsy

b At Abbott Northwestern Hospital on 2/14/18 (Procedure/Treatment Date)

c The reason for this procedure/treatment is [medical condition] abnormal LFTs

d This will be performed or supervised by Dr [redacted]

e Other team members may work with my doctor or health care practitioner This could include opening and closing the wound taking grafts cutting out tissue implanting devices I have been told who will help if known The key team members that will assist are

Name/title _____ Critical task _____
Name/title _____ Critical task _____
Name/title _____ Critical task _____

f I understand that my team members may change during the procedure

My questions have been answered I agree to the procedure/treatment My instructions and special needs are

2/14/18 [redacted]
Date Time Signature of Patient (or substitute decision maker) Relationship to Patient

Date Time Interpreter Name/Device Used (when required) Language/Organization

Practitioner Signature

The procedure and the information stated above have been discussed with the patient or the patient s substitute decision maker and all questions were answered The patient/substitute decision maker consented to the procedure

Laterality of pathology ☐ Left ☐ Right ☐ Midline ☒ N/A

Site Marking (must be completed on the day of the procedure)

☐ Site marked with patient participation (unless patient is unable to participate in site marking)
☐ Procedure meets site marking exclusi[redacted]
☒ Procedure site determined by imaging [redacted]

2/14/18 1035 PM
Date Time Practitioner Signature(s)

Witness Signature

Signed by the person witnessing or verifying the signature of the patient or the patient s substitute decision maker

☒ Witnessed the signature
☐ Verified the telephone consent
☐ Verified the signature completed previously by the patient

2-14-18 [redacted]
Date Time Signature of Witness Date Time Signature of Witness

Date Time Interpreter Name/Device Used (when required) Language/Organization

Safe Match #_____

Allina Health
ABBOTT NORTHWESTERN HOSPITAL

[redacted]