SPECIAL CONSENT FOR PROCEDURAL TREATMENT

(DIAGNOSTIC & SURGICAL PROCEDURES & OTHER INVASIVE PROCEDURES)

The law in Washington gives you the right and the responsibility to make decisions about your health care. Health care professionals can give you information and advice. You or your legal representative must be part of the decision-making. This consent form:

- Proves that you had a part in making decisions about your health care.
- Shows that you gave permission for the treatment recommended by your health care professionals.

The words "I", "my", etc., in this form mean the patient, no matter whether the patient or the patient's representative is signing the form. The term "health care professional" may mean the attending physician, but in addition may mean a different doctor (including a resident), nurse practitioner, registered nurse, or physician's assistant, who orders, performs all or part of, or is involved in explaining the procedure.

I give permission to my health care professional(s) who are listed on the back of this form as the performing provider(s), to do the procedure(s) listed on the back of this form, with anesthesia and/or sedation if that is needed. Anesthesia or sedation medicine will be given by the health care professional, anesthesiologist, or other trained health care staff who work under appropriate supervision.

I understand that the health care professional may need to perform other urgent procedures due to an emergency that may occur while I am sedated or otherwise not able to give consent. The health care professional will talk with my legally authorized representative if possible, but if it is not, I give my permission for the health care professional to do so.

I understand that the health care professional may choose assistants, including residents *(physicians who have finished medical school, but are getting more training)*, to do or help with procedures. The assistants may suture; harvest grafts; dissect, remove or alter tissue; implant devices; or do other tasks that the health care professional has discussed with me as applicable. If known, the health care professional has discussed with me whether there will be assistants and who s/he expects the assistants to be. I understand that during the procedure, the health care professional may need to choose different assistants or have them do different tasks. I understand that for some kinds of medical equipment used during procedures, a representative from the equipment manufacturer may be there, doing things like providing consultation or running checks on the equipment.

The hospital or health care professional will dispose of any removed tissues or parts.

I understand what procedure(s) will be done. I have been told about the risks and benefits. I have been told about other treatment choices and about their risks and benefits, including not having the procedure. I have been told about what results to expect, which includes information about the chances for the expected results. I know that results cannot be guaranteed. I have been told about potential problems that may occur during recuperation.

I understand that there are risks for all kinds of surgery and for "invasive procedures" *(procedures where a blood vessel, body cavity, or other internal tissue is entered with a needle, tube, or similar device)*. These risks, which can be serious, include bleeding, infection, and damage to nearby tissues, vessels, nerves, or organs. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I have received this added detailed information and/or patient information materials about the procedure(s):

_____

Print added information or title of information materials

I understand whether I will receive either anesthesia or sedation medicine, or both. I have been told about my choices for anesthesia and sedation and about their risks and benefits. I have been told about side effects of the medicine(s) and problems they may cause with recovery.

I understand that anesthesia and sedation medicines used for procedures involve risks. These risks can be serious. They may include damage to vital organs such as the brain, heart, lungs, liver, and kidneys. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I understand that the anesthesia equipment may damage my teeth or cause other dental damage.

I understand that nerve damage may occur from how anesthesia equipment is placed or how my body must be positioned during a procedure.

Continued on Reverse

[redacted]

-Conflict-of-interest statement

I understand that I am free to refuse consent to any proposed procedure.

BLOOD: I have been told whether I am having a procedure where blood or blood components *(products)* may need to be used *(also known as transfused)*. **If I am having this kind of procedure**, I have been told about side effects, risks and other choices about transfusion, including **not** getting a transfusion.

I give permission to receive blood and/or blood components if the health care team decides it is needed. I understand that use of blood and blood components involves risks. The risks may include reactions, including allergic reactions, fever, hives, lung injury, and in rare cases, infectious diseases such as hepatitis and HIV/AIDS. I know that the blood bank screens donors and matches blood for transfusions to help lower risks.

OR **(Please initial) _____ I refuse *(or partially refuse)* permission for blood and blood components. *(You will be asked to sign another form, Form UH2063).***

☒ **Interpreter** *(Print Name)* [redacted]

Giving Consent

By signing below, I confirm that I have read the sections above and that I have had 1) each item explained to me; 2) a chance to ask questions; and 3) all of my questions answered.

FULL NAME OF PROCEDURE(S)	[redacted]		
Health Care Professional(s) Performing Procedure			
SIGNATURE *(PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)* [redacted]	**PRINT NAME** [redacted]	**DATE** 10/10/16	**TIME** 3:00

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Court-appointed Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

☐ 1. Guardian/legal custodian ☐ 2. Court-authorized person for child in out-of-home placement ☐ 3. Parent(s)
☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

WITNESS SIGNATURE *(WITNESS OPTIONAL UNLESS TELEPHONE CONSENT)*	PRINT NAME	☐ TELEPHONE MONITORED CONSENT *(No patient signature)*

HEALTH CARE PROFESSIONAL'S STATEMENT

I explained the treatment/procedure(s) stated on this form, including the possible risks, complications, alternative treatments *(including non-treatment)* and anticipated results to the patient and/or his/her representative before the patient and/or his/her representative consented.

If only the patient has signed this form, in my clinical opinion, the patient is capable of making his/her own health care decisions. If in my clinical opinion, the *(adult)* patient has questionable ability to make his/her own health care decisions, I discussed the above with the patient and with the patient's legally authorized representative.

HEALTH CARE PROFESSIONAL SIGNATURE [redacted]	PRINT NAME & TITLE	NPI *(IF APPLICABLE)*	DATE 10/10/16	TIME 15:01

[redacted]

SPECIAL CONSENT FOR PROCEDURAL TREATMENT

(DIAGNOSTIC & SURGICAL PROCEDURES & OTHER INVASIVE PROCEDURES)

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The hospital or health care professional will dispose of any removed tissues or parts.

I understand what procedure(s) will be done. I have been told about the risks and benefits. I have been told about other treatment choices and about their risks and benefits, including not having the procedure. I have been told about what results to expect, which includes information about the chances for the expected results. I know that results cannot be guaranteed. I have been told about potential problems that may occur during recuperation.

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I have received this added detailed information and/or patient information materials about the procedure(s):

_____

_____

Print added information or title of information materials

I understand whether I will receive either anesthesia or sedation medicine, or both. I have been told about my choices for anesthesia and sedation and about their risks and benefits. I have been told about side effects of the medicine(s) and problems they may cause with recovery.

I understand that anesthesia and sedation medicines used for procedures involve risks. These risks can be serious. They may include damage to vital organs such as the brain, heart, lungs, liver, and kidneys. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I understand that the anesthesia equipment may damage my teeth or cause other dental damage.

I understand that nerve damage may occur from how anesthesia equipment is placed or how my body must be positioned during a procedure.

[redacted]

I understand that I am free to refuse consent to any proposed procedure.

BLOOD: I have been told whether I am having a procedure where blood or blood components *(products)* may need to be used *(also known as transfused)*. **If I am having this kind of procedure,** I have been told about side effects, risks and other choices about transfusion, including **not** getting a transfusion.

I give permission to receive blood and/or blood components if the health care team decides it is needed. I understand that use of blood and blood components involves risks. The risks may include reactions, including allergic reactions, fever, hives, lung injury, and in rare cases, infectious diseases such as hepatitis and HIV/AIDS. I know that the blood bank screens donors and matches blood for transfusions to help lower risks.

OR ***(Please initial)*** _____ **I refuse** ***(or partially refuse)*** **permission for blood and blood components.** ***(You will be asked to sign another form, Form UH2063).***

Interpreter *(Print Name)* [redacted]

Giving Consent

By signing below, I confirm that I have read the sections above and that I have had 1) each item explained to me; 2) a chance to ask questions; and 3) all of my questions answered.

FULL NAME OF PROCEDURE(S)	[redacted]		
Health Care Professional(s) Performing Procedure			
SIGNATURE *(PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)* [redacted]	**PRINT NAME**	**DATE** 11/7/16	**TIME** 1515

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Court-appointed Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

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☐ 4. Holder of signed authorization from parent(s) ☐ 5. Adult representing self to be a relative responsible for the minor's health

WITNESS SIGNATURE *(WITNESS OPTIONAL UNLESS TELEPHONE CONSENT)*	PRINT NAME	☐ TELEPHONE MONITORED CONSENT *(No patient signature)*

HEALTH CARE PROFESSIONAL'S STATEMENT

I explained the treatment/procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative before the patient and/or his/her representative consented.

If only the patient has signed this form, in my clinical opinion, the patient is capable of making his/her own health care decisions. If in my clinical opinion, the (adult) patient has questionable ability to make his/her own health care decisions, I discussed the above with the patient and with the patient's legally authorized representative.

[redacted]	NPI *(IF APPLICABLE)*	DATE 11/7/16	TIME 1515

[redacted]

SPE[illegible] CONSENT FOR PROCEDURAL T[illegible]TMENT

(DIAGNOSTIC & SURGICAL PROCEDURES & OTHER INVASIVE PROCEDURES)

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I understand the attending physician may participate in care involving overlapping procedures or oversee other urgent medical responsibilities and may not be present in the room at all times. During this time, the skilled team of assistants may perform portions of my procedure which the attending physician has determined they are proficient to perform. If an overlap is anticipated or planned, I will be notified prior to surgery. The attending physician will be present for the key and critical portions of the procedure, and either he/she or a designated attending physician will be available to the procedure team at all times.

The hospital or health care professional will dispose of any removed tissues or parts.

I understand what procedure(s) will be done. I have been told about the risks and benefits. I have been told about other treatment choices and about their risks and benefits, including not having the procedure. I have been told about what results to expect, which includes information about the chances for the expected results. I know that results cannot be guaranteed. I have been told about potential problems that may occur during recuperation.

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I have received this added detailed information and/or patient information materials about the procedure(s):

_____

_____

Print added information or title of information materials

I understand whether I will receive either anesthesia or sedation medicine, or both. I have been told about my choices for anesthesia and sedation and about their risks and benefits. I have been told about side effects of the medicine(s) and problems they may cause with recovery.

I understand that anesthesia and sedation medicines used for procedures involve risks. These risks can be serious.

Continued on Reverse

[redacted]

Go to next page

They may include damage to vital organs such as the brain, heart, lungs, liver, and kidneys. They may even result in paralysis, cardiac arrest, brain damage, and/or death.

I understand that the anesthesia equipment may damage my teeth or cause other dental damage.

I understand that nerve damage may occur from how anesthesia equipment is placed or how my body must be positionx during a procedure.

I understand that I am free to refuse consent to any proposed procedure.

BLOOD: **I have been told** whether I am having a procedure where blood or blood components (products) may need to be used (also known as transfused). **If I am having this kind of procedure**, I have been told about side effects, risks and other choices about transfusion, including **not** getting a transfusion.

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OR *(Please initial)*

_____ **I refuse *(or partially refuse)* permission for blood and blood components.** *(You will be asked to sign another form, Form LH2053).*

☐ **Interpreter** *(Print Name)* [redacted]

Giving Consent

By signing below, I confirm that I have read the sections above and that I have had 1) each item explained to me; 2) a chance to ask questions; and 3) all of my questions answered.

FULL NAME OF PROCEDURE(S)	[redacted]		
Health Care Professional(s) Performing Procedure			
SIGNATURE *(PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)* [redacted]	**PRINT NAME**	**DATE** 4/6/17	**TIME** 1445

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Court-appointed Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse/registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

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WITNESS SIGNATURE *(WITNESS OPTIONAL UNLESS TELEPHONE CONSENT)*	PRINT NAME	☐ TELEPHONE MONITORED CONSENT *(No patient signature)*

HEALTH CARE PROFESSIONAL'S STATEMENT

I explained the treatment/procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative before the patient and/or his/her representative consented.

If only the patient has signed this form, in my clinical opinion, the patient is capable of making his/her own health care decisions. If in my clinical opinion, the (adult) patient has questionable ability to make his/her own health care decisions, I discussed the above with the patient and with the patient's legally authorized representative.

[redacted]	NPI *(IF APPLICABLE)*	DATE 4/6/17	TIME 1445

[redacted]

SPECIA ONSENT FOR PROCEDURAL TRE MENT

(DIAGNOSTIC & SURGICAL PROCEDURES & OTHER INVASIVE PROCEDURES)

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I understand the attending physician may participate in cases involving overlapping procedures or oversee other urgent medical responsibilities and may not be present in the room at all times. During this time, the skilled team of assistants may perform portions of my procedure which the attending physician has determined they are proficient to perform. If an overlap is anticipated or planned, I will be notified prior to surgery. The attending physician will be present for the key and critical portions of the procedure, and other nurses or a designated attending physician will be available to the procedure team at all times.

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Print added information or title of information materials

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Continued on Reverse

[redacted]

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I **understand** that nerve damage may occur from how anesthesia equipment is placed or how my body must be positioned during a procedure.

I **understand** that I am free to refuse consent to any proposed procedure.

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I **give permission** to receive blood and/or blood components if the health care team decides it is needed. I understand that use of blood and blood components has various risks. The risks may include reactions, including allergic reactions, fever, fluid overload, lung injury and in rare cases, infectious diseases such as hepatitis and HIV/AIDS. I know that the blood bank screens donors and monitors blood for transfusion to help lower risks.

OR (Please initial)

____ I **refuse (or partially refuse) permission for blood and blood components.** (You will be asked to sign another form, Form DH2053)

☐ **Interpreter** (Print Name)_____

Giving Consent

By signing below, I confirm that I have read the sections above and that I have had 1) each item explained to me; 2) a chance to ask questions; and 3) all of my questions answered.

FULL NAME OF PROCEDURE(S)	[redacted]
Health Care Professional(s) Performing Procedure	[redacted]

SIGNATURE (PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE	TIME
[redacted]		7/18/17	8:30

IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT

☐ 1. Court-appointed Guardian ☐ 2. Durable Healthcare Power of Attorney ☐ 3. Spouse or registered domestic partner
☐ 4. Adult Child(ren) ☐ 5. Parent(s) ☐ 6. Adult Brother(s)/Sister(s)

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WITNESS SIGNATURE (WHERE OFFICIAL INTERPRETER REQUIRED)	PRINT NAME	☐ TELEPHONIC INTERPRETER (Interpreter's signature)

HEALTH CARE PROFESSIONAL'S STATEMENT

I explained the treatment/procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative before the patient and/or his/her representative consented.

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HEALTH CARE PROFESSIONAL SIGNATURE	PRINT NAME & TITLE	NPI (IF APPLICABLE)	DATE	TIME
[redacted]		371470	7/18/17	8:40

[redacted]

CONSENT FORM FOR CASE REPORTS[1]

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

Patient Name : [redacted]

Title of article: Multidisciplinary Approach to Multifocal Bilobar Hepatocellular Carcinoma; A case Report

Medical practitioner or corresponding author: [redacted]

I [redacted] [insert full name] give my consent for this information about MYSELF OR MY CHILD OR WARD/MY RELATIVE [insert full name]: [redacted], 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: 8/15/18

Signature of requesting medical practitioner/health care worker:

[redacted] Date: 8/15/18

[1] Adapted from *BMJ Case Reports* consent form
Division Research Development and Support, Faculty of Health Sciences, Stellenbosch University, South Africa. Consent form for case reports. Version1. Sept 2008.