[redacted]

6. I authorize the hospital to release, transfer, dispose of, preserve and examine for educational or scientific purposes, research with appropriate approvals, and/or donate for re-implantation, any removed tissue, blood or bone product or other surgical specimen (tissue) resulting from the procedure and relinquish any ownership rights in such tissue.

7. I consent to the taking of photographs and/or videotapes during the procedure and to the televising the procedure, including appropriate portions of my body, for medical, scientific and educational purposes, provided my identity is not revealed by the picture or by the descriptive texts accompanying them.

8. I authorize and consent to the administration of sedation upon me (my child) and to any further care that may become necessary or advisable in the course of administering sedation. Sedation is a depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, respond appropriately to physical stimulation, and allows protective reflexes to be maintained.

Deep Sedation is a medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes and includes the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command.

Sedation represents a continuum and patient may move easily from a light level of sedation to deep sedation.

Accordingly, the patient is observed and monitored until discharge criteria are met.

9. If necessary I consent to the use of local anesthetics or sedatives.

Patient signature: [redacted]

(✓) Parent ( ) Guardian ( ) Legally Authorized Representative

Date 9/7/16

Time: 0815 Witne[redacted]

Patient unable to consent because: _____

_____

( ) Interpreter services used during informed consent discussion.

Interpreter Name ID# _____

NORTON HEALTHCARE

Louisville Oncology

Authorization for Treatment

1. Consent to Medical Treatment. I voluntarily consent to care that involves routine procedures and medical treatment as prescribed by my physician.

2. Release of Information. I authorize the physician and any other holder of medical or other information about me, including medical information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions and/or blood borne infectious diseases, to release to the Social Security Administration, its intermediaries and its carriers, State agencies, the review organization employed by my employer, or the employer of the insured member of my family, or any private third-party payor, as appropriate, any information required for the completion of any claim for benefits arising out of services rendered to me.

3. Assignment of Benefits. I agree to the assignment of all third-party benefits to the physician and agree to pay for all charges not covered by third party payors.

4. Release of Insurance Information. I agree to the release by my insurance carrier to the physician and the billing service of any eligibility and utilization date information concerning my insurance coverage, which the physician and/or billing service may require.

The undersigned certifies that he/she has read and agrees to this agreement.

Signed: [redacted] dian or Representative Date: 7-16-13

Signed: [redacted] Date:

Authorizations and authorization for examination

[redacted]

AB

[X] **Palliation or Control.** In the majority of adults with cancer, cure cannot be achieved. Anticancer treatments are given because it has been found that when a tumor size has been reduced or the spread of the cancer has been slowed, the symptoms or complications of the cancer are reduced. In many forms of cancer, control of the disease also results in prolongation of life. But even when this is not possible, patients who receive anticancer treatments tend to have a better quality of life.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the therapy. I have been given the opportunity to ask questions regarding this therapy and all of my questions have been answered to my satisfaction.

Patient signature (or check below) [redacted] _____

( ) Parent Authorized Representative

Date 10/24/18

Time 1242

Witness [redacted] _____

Patient unable to consent because _____

( ) Interpreter services used during information consent discussion.

Interpreter Name/ID # _____

[redacted]

6. I authorize the hospital to release, transfer, dispose of, preserve and exa[redacted] scientific purposes, research with appropriate approvals, and/or donate for re-implantation, any removed tissue, blood or bone product or other surgical specimen(tissue) resulting from the procedure and relinquish any ownership rights in such tissue.

7. I consent to the taking of photographs and/or videotapes during the procedure and to the televising the procedure, including appropriate portions of my body, for medical, scientific and educational purposes, provided my identity is not revealed by the picture or by the descriptive texts accompanying them.

8. I authorize and consent to the administration of sedation upon me (my child) and to any further care that may become necessary or advisable in the course of administering sedation. Sedation is a depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, respond appropriately to physical stimulation, and allows protective reflexes to be maintained.

Deep Sedation is a medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes and includes the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command.

Sedation represents a continuum and patient may move easily from a light level of sedation to deep sedation.

Accordingly, the patient is observed and monitored until discharge criteria are met.

9. If necessa[redacted]etics or sedatives.

Patient signat[redacted]) Legally Authorized Representative

Date: 2/12
Time: 1130 Witness[redacted]

Patient unable to consent beca[redacted]

( ) Interpreter services used during informed consent discussion.

Interpreter Name ID# _____

[redacted]

[redacted]

5. I understand that during the course of the procedure, unforeseen conditions may require additional or different procedures than those listed above. I, therefore, authorize and request that the above-named physician, his/her associates, assistants, consultants, residents or fellows, perform such additional procedures as are deemed necessary in their professional judgement. This may include, but is not limited to, procedures involving pathology, radiology and the transfusion of blood or blood products.

6. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedures.

7. I authorize the hospital to release, transfer, dispose of, preserve and examine for educational or scientific purposes, research with appropriate approvals, and/or donate for re-implantation, any removed tissue, blood or bone product, organ or other surgical specimen (tissue) resulting from the procedure and relinquish any ownership rights in such tissue.

8. Explanted Devices: If applicable, I authorize the hospital to (please initial only one option):
____ Release explanted device to surgeon or manufacturer.
____ Dispose of explanted device immediately after surgery.
____ Release explanted device to me or legally authorized representative (hospital will retain for a maximum of 4 weeks).
IF NO OPTION IS SELECTED HOSPITAL WILL DISPOSE OF THE DEVICE IMMEDIATELY

9. If applicable, I understand that tissue and bone products (including human tissue allografts/autografts, bone chips, bone paste, cortical bone dowels, cortical rings/wedges, cervical spacers) supplied to the hospital and implanted into me (my child) are derived from me (my child), donated human cadavers, or synthetic material, and despite appropriate testing and screening by industry suppliers, inherent risks of infectious diseases cannot be fully eliminated.

10. I consent to the taking of photographs and/or videotapes during the procedure and to televising the procedure, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the picture or by the descriptive texts accompanying them.

11. I understand that there are inherent risks with the administration of anesthesia and I onsent to the administration of anesthesia and/or sedation, and to the use of such anesthetics/sedatives, with the following exception:

_____
(State exception or None)

Patient Signature (or check below): [redacted]
( ) Parent ( ) Guardian ( ) Legally Authorized Representative

Witness: [redacted] Date 8/10/17 Time 1650

Patient unable to consent because _____

( ) Interpreter services used during informed consent discussion
Interpreter Name ID# _____

[redacted]

9. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedure(s).

10. I consent to the taking of photographs and/or videotapes during the procedure(s) and to televising the procedure(s), including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the picture or by the descriptive texts accompanying them.

11. I understand that there are inherent risks with the administration of anesthesia, and I consent to the administration of anesthesia and/or sedation, and to the use of such anesthetics/sedatives, with the following exception:

_____
(State exception or none)

12. I authorize and consent to the administration of sedation upon me (my child) and to any further care that may become necessary or advisable in the course of administering sedation: 1) local anesthesia; 2) monitored conscious sedation.

Sedation is a depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, respond appropriately to physical stimulation, and allows protective reflexes to be maintained.

Sedation represents a continuum and patient may move easily from a light level of sedation to deep sedation. Accordingly, the patient is observed and monitored until discharge criteria are met.

13. If necessary I consent to the use of local anesthetics or sedatives.

Patient signature (or check appropriate box below):

[redacted] _____

( ) Parent ( ) Guardian ( ) Legally Authorized Representative

Date: 8-9-18 Time: 1120

Witness: [redacted] _____

Patient unable to consent because _____

( ) Interpreter services used during informed consent discussion.

Interpreter Name ID# _____

[redacted]

I hereby state that I have read and understand this Consent form, that I have had the opportunity to ask questions of my physician and that all my questions about the procedure have been answered to my satisfaction.

Patient Signature (or check below): [redacted]

( ) Guardian (X) Legally Authorized Representative

Date: 1/14/19 Time: 17:00

Witness Signature: [redacted]

Patient unable to consent because _____

( ) Interpreter services used during informed consent discussion.

Interpreter Name ID# _____

Implemented 8/1/2007 - Risk/Legal KLZ

TELEPHONE CONSENT

This form was read in its entirety to request for and consent to the placement of a Peripherally Inserted Central Catheter and was granted by:

Name: _____

( ) Guardian ( ) Legally Authorized Representative

Date _____ Witness #1: _____

Time _____ Witness #2: _____

PHYSICIAN OR PICC LINE R.N. SIGNATURE

Affirmation of Informed Consent

I do affirm and certify that I have informed the above-named patient or patient's authorized representative of the condition requiring the surgical treatment(s) and/or invasive procedure(s) referred to above. I have, consistent with my best medical judgement, fully explained the nature, purpose, alternatives, risks, potential complications, recovery, and likelihood for success of the treatment(s) and/or procedure(s) described. After the foregoing information had been explained, the patient or representative consented to all treatment(s) and/or procedure(s) described and accurately recounted the information presented.

[redacted] _____ / _____

Date Time

CC: [redacted]

_____ / _____

Date Time

[redacted]

Taking Glucophage (metformin hydrochloride tablets) * If yes, glucophage may be taken by a diabetic patient up to the date of the procedure in which the patient will receive iodine contrast and should be withheld for 48-hours after the procedure, until renal function is rechecked and unchanged. ( )

7. I agree that students, potential employees of Norton Healthcare, and medical students may be allowed to observe this procedure(s) for teaching purposes.

8. I understand that during the course of the procedure(s), unforeseen conditions may require additional or different procedures than those listed above. I, therefore, authorize and request that the physician and/or his/her associates, assistants, consultants, residents or fellows, perform such additional procedures as are deemed necessary in their professional judgement.

9. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedure(s).

10. I consent to the taking of photographs and/or videotapes during the procedure(s) and to televising the procedure(s), including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the picture or by the descriptive texts accompanying them.

11. I understand that there are inherent risks with the administration of anesthesia, and I consent to the administration of anesthesia and/or sedation, and to the use of such anesthetics/sedatives, with the following exception:

_____
(State exception or none)

12. I authorize and consent to the administration of sedation upon me (my child) and to any further care that may become necessary or advisable in the course of administering sedation: 1) local anesthesia; 2) monitored conscious sedation.

Sedation is a depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continuously, respond appropriately to physical stimulation, and allows protective reflexes to be maintained.

Sedation represents a continuum and patient may move easily from a light level of sedation to deep sedation. Accordingly, the patient is observed and monitored until discharge criteria are met

13. If necessary I consent to the use of local anesthetics or sedatives.

Patient signature (or check appropriate box below)

[redacted]

( ) Parent ( ) Guardian ( ) Legally Authorized Representative

Date: 7/3/13
Time: 0900

Witness: [redacted]

Patient unable to consent because _____

[redacted]

PLEASE ANSWER YES OR NO IF YOU HAVE ANY OF THE CONDITIONS LISTED BELOW:

[X] No [ ] Yes Severe Liver disease
[X] No [ ] Yes Recent or pending liver transplant
[X] No [ ] Yes Hypertension (high blood pressure) (Controlled or Uncontrolled)
[X] No [ ] Yes Diabetes
[X] No [ ] Yes Renal disease (including solitary kidney, renal transplant, renal tumor)
[X] No [ ] Yes Renal failure (note whether hemodialysis, peritoneal dialysis or no dialysis)
[X] No [ ] Yes Acute renal injury
[X] No [ ] Yes Allergies to medications/latex: 9mL Gadavist
[X] No [ ] Yes Creatinine: 2102.14 2/18
[ ] No [X] Yes GFR: _____

If you have any questions, please ask the MRI technologist so that they may answer your questions or provide you with additional information.

I have read/or have been explained and understand, the above information and have had my questions answered.

I understand and acknowledge that a contrast agent may be utilized to better diagnose my condition XJTL(initial). My physician has explained to me that this procedure is necessary to further diagnose my condition. The technologist has explained the procedure to my satisfaction. I fully understand the risks and possible consequences involved with the procedure and that unforseen results and or complications may occur if I have not answered all the questions asked truthfully.

Patient signature (or check below [redacted]
( ) Parent ( ) Guardian ( ) Legally Authorized Representative

Date: 12/23/13 Time: _____

Patient unable to consent because: _____

Witness: [redacted] _____

( ) Interpreter services used during informed consent discussion.

Interpreter Name ID# _____