MUNSON HEALTHCARE

0303

CONFIRMATION OF INFORMED CONSENT FOR PROCEDURE

You are receiving health care at a facility that is part of Munson Healthcare.
Munson Healthcare includes the following:

- ☐ Kalkaska Memorial Health Center
- ☐ Munson Healthcare Cadillac Hospital
- ☐ Munson Healthcare Charlevoix Hospital
- ☐ Munson Healthcare Grayling Hospital
- ☐ Munson Healthcare Manistee Hospital
- ☐ Munson Healthcare Otsego Memorial Hospital
- ☐ Munson Home Health
- ☐ Munson Medical Center
- ☐ Paul Oliver Memorial Hospital

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be performed, so that you may make a decision to undergo the procedure with knowledge of the risks, benefits and alternatives. This disclosure of possible risks is not meant to scare or alarm you; it is simply an effort to make you better informed so you can give, or withhold, your consent for the proposed procedure.

The procedure, treatment, or therapy (Procedure) is:

I consent to the performance of the procedure named above, by_____
Physician/Provider Name

I know that my provider may ask other healthcare providers to help with the Procedure, which may include other physicians, or other appropriate providers, and my provider has specifically identified any other providers who are likely to assist and/or perform important aspects of the Procedure. I understand that resident physicians, healthcare professionals, and healthcare students may be present to observe or assist my provider in performing the Procedure. My provider may ask a representative of a healthcare device company to be present for consultation.

I understand that no warranty or guarantee has or can be made to me as to a certain result or cure. Although all procedures differ, common risks associated with almost any procedure include infection, bleeding, damage to organs, heart or lung complications, and even death. I know unforeseen events and complications other than those discussed with me may occur, and I could be in the hospital, sick or disabled, much longer than anyone expects. I know that it is up to me to tell the providers about allergies I have, drugs or medicines I have taken, and any other health problems I have.

The most common side effects, risks and/or complications of this Procedure are:

I understand:

- General purpose and nature of the Procedure;
- Who is performing the Procedure or administering the medical treatment and other personnel who are likely to assist and/or perform important aspects of the Procedure;
- Anticipated benefits, expected outcome, and likelihood of success;
- Possible material risks, complications, serious side effects, and inconveniences;
- Expected course of recuperation;
- Possible consequences of not having the Procedure;
- Any significant alternatives therapies; and
- The risks, alternatives, and benefits specific to the use of human tissue, if applicable to my Procedure.

INSERT PATIENT ID LABEL OR ENTER PATIENT'S FULL NAME AND DATE OF BIRTH BELOW

_____
PATIENT'S FIRST AND LAST NAME

_____
PATIENT'S DATE OF BIRTH

If during this Procedure, the provider(s) find it necessary to perform additional and/or different procedures than those listed above, which are not known to be needed at the time this consent is given, I consent to the performance of such procedures.

I agree that tissues or organs taken from my body may be tested or kept for the purpose of research or teaching. I agree the hospital may discard these in a proper way.

I agree that any photographs, x-rays, or video recordings, if taken, may be included in my medical record or may be used for teaching purposes with my identity protected.

Anesthesia/Sedation: If applicable to my Procedure, I understand that receiving anesthesia and sedation also involves risks, but request their use for the relief of, and protection from, pain during the Procedure. I understand that if the involvement of an anesthesiologist or other qualified provider is deemed necessary to safely accomplish this, that person will discuss the planned anesthetic with me prior to the Procedure, in order that I may be informed and agree to the plan before I proceed with the surgery.

Medical Implants/Explants: If applicable to my Procedure, I agree to the release of my name, address, date of birth, and Social Security number, to the company that makes the medical device that is put in or removed during this Procedure. Federal laws and rules require this. The company will use this information to locate me, if needed.

Blood Transfusion: I understand that in the event of severe blood loss, I may require transfusion of blood products. There are risks with blood transfusions, including but not limited to: break down of red blood cells, fluid in the lungs, fever, chills, allergic reaction, infection such as hepatitis, HIV (AIDS). I know that in an emergency, I may need blood products before all laboratory tests are done.

Other:

By signing this form, I agree:

- I have read this form, or had it read and explained to me;
- I fully understand its contents;
- I have been given time to ask questions and I have had my questions answered satisfactorily;
- I have talked with my provider or other healthcare staff in words I can understand; and
- I want to consent to the Procedure described above.

SIGNATURE OF PATIENT/PARENT OF MINOR/LEGAL GUARDIAN OR REPRESENTATIVE (RELATIONSHIP, IF NOT PATIENT) **DATE** **TIME**

PROVIDER SIGNATURE **DATE** **TIME**

INSERT PATIENT ID LABEL OR ENTER PATIENT'S FULL NAME AND DATE OF BIRTH BELOW

PATIENT'S FIRST AND LAST NAME

PATIENT'S DATE OF BIRTH

This consent is greater than 90 days old. Please review and complete below:

Attestation: Patient and Provider agree, there has been no change in patient condition which would alter or modify the risks, benefits, and alternatives discussed. Any additional questions were reviewed.

Patient Signature: _____ **Date:** _____ **Time:**_____

Provider Signature: _____ **Date:** _____ **Time:**_____