BASIC ELEMENTS OF AN INFORMED CONSENT DOCUMENT

(Name [common and technical] and brief description of the procedure to be performed.)

Patient's
Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks, and disadvantages have been explained to me.

_____ I understand and accept that the most likely material risks and complications of (procedure name) have been discussed with me and may include but are not limited to:

-
- (Include common complications/risks)
-

_____ I understand and accept that complications exist, including the remote risk of death or serious disability, with any surgical procedure.

_____ I understand and accept the risks of blood or blood products transfusion(s) that may be necessary (if applicable). *[Note: use a separate consent form for blood or blood products.]*

_____ I understand that tissue cannot heal without scarring and that scarring is dependent on individual genetic characteristics. The healthcare provider will do his/her best to minimize scarring but cannot control its ultimate appearance.

_____ I am aware that smoking or using other inhalation products (including tobacco, e-cigarettes, and vaping) during the pre- and postoperative periods could increase chances of complications. I have been advised to discontinue use of these products.

_____ I have informed the healthcare provider of all my known allergies.

_____ I have informed the healthcare provider of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised when to stop and when to resume taking any or all of these medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity and pain levels, and the possibility of additional procedures.

_____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation and will be maintained or destroyed in accordance with the protocols of the laboratory.

_____ Pre- and postoperative photos, images, and/or videos may be taken of the treatment for healthcare record purposes. I understand that these photos, images, and/or videos will be the property of the attending healthcare provider and will be protected in accordance with federal and state privacy laws.

_____ The healthcare provider has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____ with associates or assistants
(Name of healthcare provider)
of his or her choice, to perform the procedure of _____
(Procedure name)
on _____ _____
(Patient name) (Date of birth)
at _____
(Facility name)
on my _____.
(Left, right, level, body part)

_____
Patient or Legal Representative Signature/Date/Time

_____
Print Patient's or Legal Representative's Name

_____
Legal Representative's Relationship to Patient

_____
Witness Signature/Date/Time

_____
Print Witness's Name

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

_____
Healthcare Provider Signature/Date/Time