35258
CH-1096 (JAN 12)
Effective 2012

Indiana University Health

CONSENT FOR PROCEDURE

By signing this form, I agree to the procedure(s) listed here. _____

_____

_____

_____

to be done by _____ , _____
members of Indiana University Health medical or other licensed personnel staff.

From this point on

- all procedures will be called the "procedure"; and
- the persons performing the procedure will be called "treating practitioner".

The exceptions to my consent are as follows:

_____

_____

I understand and agree to the following items.

- Residents and students may help with my care.
- Medical staff other than the treating practitioner may do part of my procedure.
- Industry representatives may be in the room to consult during my procedure.
- The treating practitioner may do other procedures not listed here if they are needed.
- A bad outcome may occur. A bad outcome does not mean care was not appropriate.
- The anesthesiologist or treating practitioner will give me an anesthetic. I have been told about the risks of anesthesia. These include death, injury to my teeth, throat and mouth, other injury and damage to my dentures.
- I agree to get blood and/or blood products any time during this hospital stay if the treating practitioner thinks I need it. I have been told about the risk of getting blood. I have been told if there are other choices. If I need blood or blood products, I agree to the risks that include allergic reactions, infections (hepatitis and AIDS), intravascular fluid overload, and chemical imbalances.
- Parts of my body taken out during surgery can be thrown away or used for research so long as my name is not used.
- Pictures may be taken and used for teaching as long as my name is not used.
- I have talked with the treating practitioner about the procedure, why I need it, the expected outcome, the risks, the chances of success, risks, benefits and results of other treatments, and what could happen if I do not have the procedure.
- I have been told about other choices, including not having the procedure, other procedures, medicine, and therapy.
  Other choices: _____
  _____
- I have been told about the risk of the procedure, which include but are not limited to bleeding, infection, injury, scarring, damage to parts of my body, and death. Other risks: _____
  _____
  _____

_____
Signature of Patient/Surrogate

_____
Time Signed Date Signed

_____
If Signed by Surrogate, Relationship to Patient

OPTIONAL

_____
Additional Adult Witness Signature

_____
Time Signed Date Signed

TREATING PRACTITIONER USE ONLY

I have discussed with the patient the nature of the proposed care, treatment, services, medications, interventions or procedures; the potential benefits, risks or side effects, including potential problems related to recuperation; the likelihood of achieving care, treatment and service goals; the reasonable alternatives to the proposed care, treatment and service; the relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services; and when indicated, any limitations on the confidentiality of information learned from or about the patient.

Signed: _____ **Date:** _____ **Time:** _____

DOCUMENTATION OF EMERGENT/URGENT PROCEDURE

This procedure was performed emergently.

Signed: _____ **Date:** _____ **Time:** _____

Indiana University Health

UNIVERSAL PROTOCOL CHECKLIST

To be completed by Licensed Professional

Patient Sticker

Procedure(s): _____

Date of Procedure: _____

PRE-PROCEDURE ITEMS ADDRESSED AND MATCHED TO PATIENT

	INITIAL BOX YES	INITIAL BOX N/A
Correct patient verified using 2 patient identifiers		
The proceduralist available		
History and Physical or Current Clinical Note for bedside procedures		
Consent form(s) accurate, completed and signed		
Pre-Sedation/Pre-Anesthesia Assessment		
Diagnostic, radiology, pathology or biopsy results available		
Implants/Devices or special equipment available		
Any required blood products available		
Site marked with ***"YES"*** by proceduralist(s) or qualified designee		
Alternative to site marking		

Time Completed: _____

FIRST TIME-OUT: COMPLETED ON PATIENT ENTRY TO PROCEDURE AREA/PRIOR TO BEDSIDE PROCEDURE

	INITIAL BOX YES	INITIAL BOX N/A
Allergies Verified		
Procedures match consent		
Verbal acknowledgement from all members of the Procedure team who are present		

Time Completed: _____

SECOND TIME-OUT: REQUIRES ACTIVE COMMUNICATION AMONG ALL MEMBERS OF THE PROCEDURE TEAM INCLUDING THE PHYSICIAN/PROCEDURALIST

	INITIAL BOX YES	INITIAL BOX N/A
Correct patient verified using 2 patient identifiers		
Correct site confirmed and marked		
Verbal agreement procedure(s) match consent		
Relevant images displayed and labeled with correct patient identifiers		
Antibiotic administered		
Fluids available for irrigation or flushes		
DVT/VTE prophylaxis		
Safety Precautions based on patient history or medication use		
Correct patient position		
Verbal acknowledgement from all members of the procedure team		

Time Completed: _____

CLOSING TIME-OUT/UPON COMPLETION OF PROCEDURE

	INITIAL BOX YES	INITIAL BOX N/A
Consents reviewed – all procedures have been completed		
Specimens addressed, labeled and identified		
All foreign bodies not intended for implantation have been removed		
Counts addressed *(for OR and other invasive procedural areas)*		
Verbal acknowledgement from all members of the procedure team		

Time Completed: _____

INITIALS: _____ **SIGNATURE:** _____

INITIALS: _____ **SIGNATURE:** _____

INITIALS: _____ **SIGNATURE:** _____

INITIALS: _____ **SIGNATURE:** _____