Cincinnati Children's Hospital Medical Center

Informed Consent for Surgical / Medical Procedure

Procedure _____ of _____

Patient Name: _____
DOB: _____
MRN: _____ (if available)

Attending Physician(s): _____

Name and purpose of procedure(s) (number multiples): _____

_____

Potential risks of any procedure(s) include, but are not limited to, bleeding, infection, accidental injury to a nearby body part, incomplete repair, and death. Other reasonably common risks to this specific procedure(s) include: _____

_____

Benefits and expected outcomes (list): _____

_____

Alternatives, including, but not limited to, no treatment: _____

_____

This procedure will be performed with: ☐ general and/or regional anesthesia, ☐ sedation, ☐ local anesthesia.

I understand that the doctor(s) may find unexpected conditions during the procedure(s) named above. An unexpected condition may require a change in procedure. I give my permission for the doctor(s) identified on this form to either *extend* the planned procedure (do more) or do a *different* procedure, if she/he believes it is medically necessary for my health / health of the patient.

I understand that Cincinnati Children's Hospital Medical Center is a teaching hospital. One of the activities of the hospital is training doctors, nurses, and other health care providers. Interns, residents, nurses, medical students and other health care workers may assist in the procedure under my doctor's direct supervision. I give my permission for this assistance.

My questions about the procedure(s) have been answered to my satisfaction. **I also understand that if I have more questions at any time before the procedure(s), I can call my doctor's office at _____.** I have read and understand this consent form and all of the blanks were filled in before I signed it. By signing, I confirm to the best of my knowledge that the law allows me to consent to the procedure(s) for this patient.

DATE: TIME:

Signature of patient / parent / guardian — Print name of patient / parent / guardian and relationship

DATE: TIME:

Signature of doctor — Print name of doctor

DATE: TIME:

Signature of witness — Print name of witness

SITE MARKING REQUIRED: ☐ YES ☐ NO

Telephone consent was obtained: ☐ YES (check, if necessary)