CONSENT FOR BEDSIDE PROCEDURE

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

- Arthrocentesis
- Aspiration
- Biopsy
- External Ventricular Drain
- Incision & Drainage
- Insertion of Arterial Line
- Insertion of Central Lines Including PICC
- Insertion of Chest Tube
- Insertion of Pulmonary Artery Catheter
- Intracranial Pressure Monitoring
- Paracentesis
- Percutaneous Endoscopic Gastrostomy Tube
- Percutaneous Needle Aspiration
- Thoracentesis
- Insertion of Arterial Line
- Insertion of Central Lines Including PICC
- Insertion of Pulmonary Artery Catheter
- Intracranial Pressure Monitoring
- Paracentesis
- Percutaneous Endoscopic Gastrostomy Tube
- Percutaneous Needle Aspiration
- Thoracentesis

to be done by ____________________________, members of Clarian Medical Staff or other appropriate licensed personnel.

From this point on:

- all procedures will be called the “Procedure”.
- the people performing the Procedure will be called “Treating Practitioner”.

The exceptions to my consent are:

I understand and agree that:

- 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 may 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.
- Parts of my body taken out during the procedure can be thrown away or used for research as 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
  - The risks
  - Why I need it
  - The chances of success
  - Risks, benefits and results of other treatments
  - Other choices: ____________________________
  - The expected outcome

- I have been told about other choices, including:
  - Not having the Procedure
  - Medicine
  - Other procedures
  - Other choices: ____________________________
  - Therapy

- I have been told about risks of the Procedure, which include:
  - Bleeding
  - Damage to parts of my body
  - Other risks: ____________________________
  - Infection
  - Scarring
  - Injury
  - Death

Date and Time of Signature

________________________________________

Patient’s Name (please print)

____________________________

Parent's Signature

____________________________

Parent, Guardian or Other Signature (If patient is not competent to sign) Relationship of Signer to Patient

____________________________

Name of Adult Witness (please print) Date & Time

____________________________

Signature of Adult Witness

[ ] 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: ____________________________

DOCUMENTATION OF EMERGENT/URGENT PROCEDURE

[ ] This procedure was performed emergently.

Signed: ____________________________ Date: ____________________________