INFORMED CONSENT FOR TREATMENT/PROCEDURE

PATIENT NAME:
DIAGNOSIS/CONDITION HEMOCHROMATOSIS
DATE OF TREATMENT/PROCEDURE:

I hereby authorize Practitioner) and/or such assistants as may be selected by him/her to perform the following treatment/procedure: PHLEBOTOMY

RISKS OF PROPOSED OPERATION/PROCEDURE. (Practitioner) has discussed with me the above procedure or treatment, the anticipated benefits, material risks, and alternative therapies. This authorization is given with the understanding that any treatment/procedure and recuperation involves some risks and hazards. The more common risks include infection, bleeding, nerve injury, blood clots, heart attack or other adverse cardiac complication, allergic reactions, severe blood loss, risks of blood transfusion (see below), and NAUSEA, VOMITTING, DIZZINESS, FAINTING, HEMATOMA (BRUISE FROMBLOOD LEAKING UNDER SKIN AT NEEDLE PUNCTURE SITE), SEIZURES OR LOCAL INFECTION (complete as discussed with patient if not documented elsewhere). These risks can be serious and possibly fatal.

ADDITIONAL PROCEDURES. I understand that other problems/conditions may develop in the course of the treatment/procedures that cannot be reasonably foreseen. It is also possible that my physician may discover a different, unsuspected condition at the time of the procedure. I authorize the above named physicians, his/her assistants or designees as indicated in the chart below, to perform such unforeseen procedure(s) that are necessary according to their medical judgment.

ASSISTANTS. I understand that some aspects or important tasks of this treatment/procedure may be performed by healthcare providers other than the primary surgeon/practitioner (i.e., residents, physician assistants, advanced practice nurses, etc.) I understand that the care provided by these practitioners will be within the scope of their practice or privileges granted and will be performed in accordance with the state law and the hospital's policies and, in the case of residents, based on their skill set and under the supervision of their responsible practitioner.

(Patient Initial Here) N/A **IMPLANTS/DEVICES IMPLANTED DURING OPERATION/PROCEDURE.** I am aware that some surgical procedures require the implantation of medical devices and the federal laws and regulations require manufacturers to track these devices. If applicable to this procedure, I understand the physician and/or medical facility will release my Protected Health Information to the appropriate device manufacturer(s) per State and/or Federal regulations.

(Patient Initial Here) N/A **MEDICAL PRODUCT REPRESENTATIVE.** It has been explained to me that a Medical Product Representative will be present for observation and/or verbal instructional purposes only during my treatment/procedure. These individuals may include other physicians, nurses, nursing students, participants in authorized educational and training programs, and vendors. I understand the reason for their presence during my treatment/procedure and consent to have them in the room.

BLOOD TRANSFUSIONS. It has been explained to me that I may need a transfusion of various blood components or derivatives. I understand that there are risks associated with the transfusion of blood or blood products. These risks include serious reactions (allergic and other reactions including headaches, itching, rash, hives, nausea, transient fever, or chills), damage to my own blood cells, volume overload which could affect heart and lungs and infections such as hepatitis and AIDS. These risks can be serious and possibly fatal. General alternatives to blood transfusion have been explained to me including the risks and consequences of not receiving this treatment. Alternatives to donor blood including pre-donation of my own blood (autologous blood donation), directed donations, epogen therapy, and use of a cell saver during surgery have been explained to me. I also understand that if I refuse blood or blood products, possible risks may include organ damage from inadequate oxygen (such as heart attack or stoke), inability to control bleeding, and sometimes even death.

(Patient Initial Here) N/A I consent to a blood transfusion if my physician determines it is needed.
(Patient Initial Here) N/A I DO NOT consent to a blood transfusion

_____ Date: _____ Time: _____
Signature of Practitioner who conducted the informed consent discussion.

PATIENT CONSENT
My doctor has fully explained the procedure in words I understand, and I understand that no guarantees have been made to me regarding the results of this treatment/procedure and that it may or may not improve my condition. I have had sufficient opportunity to discuss my condition and treatment with my physicians and/or their associates, and all of my questions have been answered to my satisfaction. I believe that I have been given sufficient information and adequate knowledge upon which to make an informed decision about undergoing the proposed treatment/procedure. I have been informed of alternatives to this procedure and the risks of the alternatives. I have read and fully understand this form and I voluntarily authorize and consent to this treatment/procedure.

_____ Date: _____ Time: _____
Signature of Patient or Legal Guardian