T-CS0004

San Francisco
Health Network
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

NAME

DOB

MRN

PCP

Patient ID / Addressograph

Consent for Treatment or a Procedure

MY RIGHTS--

I understand that I have the right to make decisions about my health care. I also understand that my doctor or other health care provider will give me information about the treatment or procedure he or she recommends. This information will include:

1. What the doctor/provider plans to do
2. Who will do the treatment or procedure
3. How it may help me
4. Possible unplanned problems
5. Other things that could be done instead

WHAT--

My doctor or provider recommends that I have the following treatment or procedure:

Medical Terminology: _____

_____

General Description (Lay Terminology): _____

_____

_____

Site, if applicable (e.g., laterality, tooth number, digit) _____

During the procedure, my condition may change or my doctor may find that additional or different procedures may be needed to treat my condition. I understand that my doctor will use her/his best judgment in deciding how to treat my condition.

WHO--

The **attending doctor or doctors** responsible for the treatment or procedure are _____.

_____

I understand that San Francisco General Hospital is a teaching hospital. Resident doctors and other doctors in training may perform important parts of the treatment or procedure. Attending doctors supervise the resident doctors and other doctors in training. Other licensed health care workers (such as nurse practitioners or physician assistants) may also perform some procedures or tasks, but only when permitted by California law and hospital policy.

WHY--

The reason for the treatment or procedure is: _____.

OTHER OPTIONS--

Instead of this procedure, the following could be done:

☐ Nothing ☐ Other: _____

The risks of the above alternative options are: _____

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OUTCOME--

The chance of a successful outcome is

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐_____

There is a possibility that the treatment or procedure will not be successful or that it may cause an unexpected, new problem.

RISKS--

My doctor or provider has explained that there is some risk in all medical treatments and procedures. She or he has explained to me some of the common and serious risks associated with the recommended treatment or procedure. Some (**but not all**) of these risks may include bleeding; infection; damage to close-by blood vessels, nerves, organs or other tissue; disability or death. Other risks: _____

TISSUE STUDY--

I understand that any tissue removed during surgery will first be studied to better understand my medical condition and how best to treat it. Any tissue that is left over may be appropriately disposed of or saved for future study. If the tissue is saved for future study:

- My privacy will be protected.
- I may not receive any direct benefit, but the study may lead to discoveries that will help others in the future.
- I will not receive any payment for the study.

I agree that my tissue may be saved for future study, but with the following conditions (**if any**):

_____

Before you sign, do you have any questions?

MY CONSENT--

I have received the information described above. My doctor or provider has answered my questions. I wish to have the recommended treatment or procedure.

- **Patient / Representative**: Date: _____ Time: _____

  Print Name_____ Signature_____ Date of Birth _____

  If a surrogate, relationship: ☐ Spouse/Domestic Partner, ☐ Parent, ☐ Adult Child

  ☐ Other Family Member: _____, ☐ Power of Attorney for Health Care,

  ☐ Conservator, ☐ Surrogate orally designated by patient during this admission

- **Interpreter**: Date: _____ Time: _____

  _____ /_____/_____

  Print Name | Signature (if in person) | Interpreter ID#

- **Witness (Member of Healthcare Team)**: Signature:_____

  Date: _____Time:____Name:_____/_____

  Print Name | Title

- **Witness**:

  Date: _____ Time: ____ Print Name: _____ Signature: _____

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PHYSICIAN PROGRESS NOTE FOR INFORMED CONSENT

Complete 1, 2 *OR* 3 below

1. CONSENT DISCUSSION WITH PATIENT OR SURROGATE (Complete this section together with the consent form which is signed by the patient or surrogate.)

a. As indicated on the **Consent Form** I explained the following to the patient or her/his surrogate:

--nature of the procedure or treatment,
--why it's recommended and the possible benefits,
--risks, benefits, and complications (most common and serious),
--alternative treatments and the risks of each (including no treatment), and
--who will perform the procedure or treatment.

☐ At the patient's request, a friend(s) or family member(s) was present during the discussion _____.

b. ☐ An interpreter was involved. [Use a trained medical interpreter (**ext. 6-5133**) except in urgent situations or if a patient specifically requests that an adult family member serve as the interpreter.]

c. ☐ Patient has **Do Not Attempt Resuscitation (DNAR)/Do Not Intubate (DNI)** order; I explained to the patient or surrogate that the order will be suspended during the procedure.

d. ☐ Teach-Back (The patient or surrogate was able to tell me what treatment / procedure is planned, why it's needed, the benefits and some of the risks that s/he might expect.)

✔ Date:_____Time:_____Provider:_____/_____/_____/CHN ID#:_____
Print Name Signature Title

2. EMERGENCY [Complete this section when neither the patient nor a surrogate can give consent and clinically the procedure cannot be delayed to allow the hospital to petition the court for an order authorizing treatment--"*medical probate*". The consent form (*pages 1 & 2*) is not completed.]

In my clinical judgment the patient emergently needs the following treatment or procedure to alleviate severe pain or to diagnose and treat a condition that may lead to a serious disability or death; **AND** ☐ The urgency of the situation precluded getting the patient's consent in advance; **OR** ☐ I have assessed the patient and determined that s/he lacks the capacity to make health care decisions and have not been able to readily identify or locate a surrogate decision maker.

Treatment/Procedure: _____

Date:_____Time:_____Provider:_____/_____/_____/CHN ID#:_____
Print Name Signature Title

Consent for Treatment or a Procedure

3. TELEPHONE CONSENT [Complete this section when a surrogate gives consent by telephone. The consent form (*pages 1 & 2*) is not completed.]

I assessed the patient and determined that (1) s/he lacks the capacity to make health care decisions or (2) s/he is a minor. I have located a family member or other authorized representative who is willing to act as the patient's surrogate health care decision-maker, but who cannot be physically present to sign the consent form. By telephone I discussed the nature of the treatment/procedure, expected outcome, risks and benefits and alternatives with the patient's surrogate.

- **Treatment/Procedure**:

  _____

- **Risks explained**:
  I explained that some (**but not all**) of these risks may include bleeding; infection; damage to close-by blood vessels, organs or other tissue; disability or death.

  Other risks:_____

- The surrogate has consented to the treatment/procedure on behalf of the patient.

  _____ _____ _____
  (Surrogate's Name) (Date Of Birth) (Telephone No.)

- Surrogate's relationship to patient:

  ☐ Spouse/Domestic Partner, ☐ Parent, ☐ Adult Child, ☐ Other Family Member (relationship): _____, ☐ Power of Attorney for Health Care, ☐ Conservator, ☐ Surrogate orally designated by patient during this admission

✓ Date:_____ Time: _____

Provider:_____/ _____/_____/_____
Print Name Signature Title CHN ID#

- Staff who was a **witness** to the telephone call:

✓ Date:_____Time:_____Name:_____/_____/_____
Print Name Signature Title