CONCORD HOSPITAL
250 Pleasant Street, Concord, NH 03301
(603)225-2711 **www.concordhospital.org**

DIAGNOSTIC, THERAPEUTIC OR OPERATIVE PROCEDURE CONSENT

PATIENT LABEL

1. I hereby authorize Dr._____ and/or such designees as may be selected by him/her to perform the following procedure(s) upon:

   Name of patient:_____ DOB:_____

   Name of procedure:_____

   _____

2. I have been informed by _____ of the following:
   - **A.** The type and purpose of the procedure(s)
   - **B.** The risks of the procedure(s)
   - **C.** The possible consequences of the procedure(s)
   - **D.** Alternative procedure(s)
   - **E.** The likely progression of my condition if no treatment is received
   - **F.** Procedure info sheet provided? ☐ Yes ☐ No

3. I acknowledge that this procedure has been explained to me in terms that I understand, and no guarantees or promises have been made to me concerning the results of the procedure(s).
4. I understand that during the course of the procedure(s) unforeseen conditions may arise or be discovered which require the performance of additional procedures, and I hereby consent to the performance of such additional procedures, as my provider believes to be necessary or advisable.
5. I understand that sedation/anesthesia may be required for this procedure. I have discussed with my provider the risks, benefits, and alternatives to sedation/anesthesia. I acknowledge that the more serious potential risks and consequences of sedation/anesthesia include, but are not limited to: changes in blood pressure, loss of or changes in memory, infection, cardiac arrest, brain damage, nerve damage, paralysis, or death. I understand that ***if I am pregnant***, anesthesia may carry an increased risk of birth defects or miscarriage.
6. I understand that a blood transfusion may be necessary. I have discussed with my provider the risks, benefits, and alternatives to transfusion. I acknowledge that, among other risks, there are small risks of transfusion reaction and transmission of infectious diseases, such as hepatitis or HIV. I hereby consent to transfusion of blood.
7. I hereby authorize Concord Hospital to dispose of or retain for diagnostic, therapeutic, research, or educational purposes any tissues or body parts removed as part of my care.
8. I understand that Concord Hospital may photograph or videotape my surgical procedure or treatment for the advancement of medical care and education unless I expressly request otherwise. I understand that if this occurs my identity will remain totally confidential.
9. I understand that many of the providers on staff at this hospital are not employed by the hospital, nor are they agents of the hospital. They are independent practitioners.
10. I understand that at this hospital there are residents, medical, nursing and other health care students that may be present during and assist in my care as part of their education unless I request otherwise.
11. I recognize that I may revoke all or any part of this consent for treatment before the procedure is performed or any associated test, medication or treatment is administered.
12. I certify that I have read this consent (or _____ has read it to me).
13. This consent is valid for 30 days unless otherwise indicated _____.

_____ _____
Patient signature **Witness signature**

_____ _____
Date **Time** **Date** **Time**

_____
Provider signature

_____
Date **Time**

IF PATIENT IS UNABLE TO CONSENT FOR SELF USE REVERSE SIDE OR PAGE 2

* CNTT *

PATIENT LABEL

USE THIS SIDE ONLY IF PATIENT IS UNABLE TO GIVE CONSENT
******Complete section I and either section II or section III******

I. INFORMED CONSENT BY LEGALLY RESPONSIBLE PERSON
PATIENT IS UNABLE TO PERSONALLY CONSENT TO PROCEDURE(S) BECAUSE:

_____

Signature of person consenting to treatment	**Signature of witness**
Print name of person consenting to treatment	**Relationship of consenting person to patient**
Date **Time**	

II. INFORMED CONSENT BY TELEPHONE

A. Telephone consent must be obtained by a provider and listened to by one other witness.

B. The consenting party must be informed by a provider about the aspects of the procedure they are being requested to consent to, including any potential anesthesia administration.

C. Attempts to reach an appropriate consenting party must be documented in the medical record.

D. The following information should be asked of the consenting party. Their answers, or their inability to answer, should be documented on the appropriate form or the medical record:

1. Full name and address of patient
2. Full name and address of consenting party
3. Relationship of consenting party to patient
4. Telephone number where consenting party can be reached
5. Information concerning pertinent history such as allergies, tetanus shots, and current medications, if known
6. The fact that the consenting party either granted or refused consent
7. Limitations or restrictions imposed by the consenting party

Signature of provider obtaining consent	**Signature of witness to telephone consent**
Print name of person granting consent	**Relationship of consenting person to patient**
Date **Time**	**Telephone area code and number**

III. TELEPHONE VERIFICATION OF INFORMED CONSENT

If possible fax or read the authorization to the legally responsible consenting person. Two witnesses, at least one must be a RN, verify by phone that the consenting person has been informed by the provider of the risks, benefits and alternatives to surgery or procedures and agrees to consult on behalf of the patient.

Signature of verifying RN to telephone consent	**Signature of verifying witness to telephone consent**
Print name of person granting consent	**Relationship of consenting person to patient**
Date **Time**	**Telephone area code and number**