Oregon Health & Science University
Hospitals and Clinics

CO1400

ACCOUNT NO.
MED REC. NO. 00555454
NAME Posner, Rebecca
BIRTHDATE 4/4/1943

PATIENT INFORMED CONSENT FOR RENDERING OF MEDICAL SERVICES/ SURGICAL SERVICES/SEDATION

Patient Identification

Dr(s). I am Attending / I am resident will perform the following **procedure(s)**:
(Print First/Last Name)

central line placement

Procedure Site (mark one box, or for multiple procedures, indicate sites above): ☐ Not applicable
☐ Right-side ☒ Left-side ☐ Bilateral ☐ Multiple sites, see above
☐ Level _____ ☐ Anterior approach ☐ Posterior approach

Physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with hospital policy and, in the case of the residents, based on their skill set and under the supervision of the responsible practitioner.

Qualified medical practitioners who are not physicians who will perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital.

The physician or practitioner has explained to me, in a way that I understand, the planned procedure or treatment, anticipated benefits, material risks or potential problems that might occur during the procedure or during recuperation as well as the likelihood of achieving our goals. He/she has also discussed alternative therapies, including no treatment, as well as the anticipated benefits and risks associated with those alternative treatments. The following are among the risks or concerns discussed:

pain, bleeding, infection, damage to surrounding structures, pneumothorax

(Specific risks or concerns discussed with the patient)

I acknowledge and agree to the following statements marked by the Practitioner as applicable to my procedure:

☐ **Blood transfusion** may be required during or after the procedure(s). Risks and alternatives to transfusion have been explained to me and I consent to receive blood or blood products as deemed necessary and appropriate by the physician.

☒ **Sedation** will be managed by the physician performing the procedure(s). Risks and alternatives to sedation have been explained to me and I consent to receive sedation.

☐ **Sedation or anesthesia** will be managed by the Anesthesiologist. The Anesthesiologist will discuss the risks, benefits, and alternatives, and answer my questions prior to my procedure.

☐ **Another qualified practitioner** that practices with the practitioner(s) listed above may perform all or a part of my procedure or treatment. I consent to having another qualified practitioner perform all or a part of my procedure or treatment.

Patient/Consenter Initials _____

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☐ **A vendor and/or observer** will be present during my procedure for a purpose which has been explained to me.

☐ **Photos/Audio and Video Recordings** may be taken while receiving medical services at OHSU for OHSU's purposes only (consistent with state and federal law). I hereby consent to OHSU taking photos/recordings of me for treatment, education, reimbursement, and/or certain administrative and business activities supporting the delivery of care at OHSU. If patient photos or recordings will be used for other purposes, additional patient authorization will be requested as required by law.

Patient/Consenter Initials _____

I hereby consent for OHSU to **retain and use removed tissues or body parts** for examination and diagnosis and to dispose of what is removed, except:_____

☐ I have no objections or exceptions **Patient/authorized consenter initial:** _____

My physician or practitioner has asked me if I want a more detailed explanation of the above and if I have any additional questions. My questions have been answered. The procedures, treatments, other alternative procedures, methods of treatment, and risks have been explained to me in substantial detail. I am satisfied with my physician's explanations.

I give my permission and consent to the treatment(s) or procedure(s) specified above:

_____ / / : ☐am ☐pm
(Patient's Signature*) (Print First/Last Name) (Date) (Time)

I EXPLAINED THE ABOVE PROCEDURE(S) TO THE PATIENT:

_____ / / : ☐am ☐pm
(Qualified Personnel's Signature) (Credentials) (Print First/Last Name) (Date) (Time)

☒ *Patient is unable to consent because: sedation/intubation

If the Patient is unable to consent, complete Section A, B or C below, as applicable.

A. The patient has a Legally Recognized Health Care Representative:

As the Patient's (check **one**): ☐ Parent (if patient is a minor); ☐ Legal Guardian; ☒ Health Care Representative, I give my permission and consent for the patient to the treatment(s) or procedure(s) specified above:

_____ 2/27/18 3:06 ☐am ☒pm
(Authorized Consenter's Signature) (Print First/Last Name) (Date) (Time)

I EXPLAINED THE ABOVE TREATMENT(S) OR PROCEDURE(S) TO THE PATIENT'S LEGALLY AUTHORIZED HEALTH CARE REPRESENTATIVE.

ICU Resident MD ICU Resident 2/27/18 3:00 ☐am ☒pm
(Qualified Personnel's Signature) (Credentials) (Print First/Last Name) (Date) (Time)

B. The patient does NOT have a Legally Recognized Health Care Representative:

As the patient's (fill in relationship to patient) _____, I agree that the treatment(s) or procedure(s) have been fully explained to my satisfaction, is in the best interest of _____, and I consent for the patient:

_____ / / : ☐am ☐pm
(Consenter's Signature) ((Print First/Last Name)) (Date) (Time)