

1. Physicians or other authorized providers at Children's Hospitals and Clinics of Minnesota **may** perform the treatments, procedures and or surgery necessary to treat or make a diagnosis upon

(Name of Patient)
2. The reason for the procedure has been discussed with me.
3. **The surgical/procedural site has been identified and marked, if appropriate.**
4. **The following topics have been discussed with me (If I don't understand I will ask questions.)**
 - a. What the procedure is and what will happen.
 - b. How it may help (the benefits).
 - c. How it might harm (the most likely and most serious risks).
 - d. The long-term effects it might have.
 - e. Other choices for treatment, and the risks and benefits of those choices.
 - f. What will likely happen, if I say no to this procedure.
 - g. What medicines may be used to manage pain or for sedation.
 - h. What is done to minimize surgical site infection.
 - i. If there is an unexpected exposure to blood or body fluids I will be informed. The patient's blood will be drawn and tested for HIV and hepatitis. The results of the patient's blood test will go
 - to me
 - in the medical record
 - to the Employee Health Services Department and/or Infection Control at Children's
 - to Minnesota health officials
5. **I agree with the following statements: (If I do not agree with a statement, I have discussed it with my physicians or other authorized providers.)**
 - a. I will ask questions.
 - b. No one has promised a certain result for this procedure.
 - c. If serious problems are found during the procedure, the treatment may change.
 - d. Students and others may watch the procedure, if approved by Children's.
 - e. Pictures or videos may be taken. They may be used for medical or educational purposes only.
 - f. Tissues or organs removed from the patient may be tested, and used for teaching purposes. They will be disposed of with respect.
 - g. The likelihood of a blood transfusion, and the risks, benefits, and alternatives to the transfusion of blood or blood products has been discussed with me. Blood or blood products may be used as necessary if related to this procedure.
 - h. The need for tissue or other biologic material has been discussed with me. Tissue or biologic materials may be used as needed if related to this procedure.
 - i. I have informed the Physician or other authorized provider of any changes to the condition of my child since the history and physical examination was performed.
6. **I understand that:**
 - a. I can change my mind. If I do, I must tell the physicians or other authorized providers before the procedure starts.
 - b. Physicians or other authorized providers may have help from others. Help could include opening and closing the wound. Help might be taking grafts, cutting out tissue, implanting tissue or devices, administering anesthesia or sedation and placing invasive lines.
 - c. "Do Not Resuscitate" (DNR) instructions are cancelled during the procedure, and must be renewed after the procedure.
 - d. If unexpected emergency treatment for a minor, including blood products becomes necessary during the procedure it will be provided without consent from the parents or legal guardian.

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PLACE PATIENT LABEL HERE

**CONSENT FOR SURGERY/ INVASIVE PROCEDURE
and/or ANESTHESIA/SEDATION**

- e. Pictures or videos may be taken. They may be used for medical or educational purposes only.
- f. Tissues or organs removed from the patient may be tested, and used for teaching purposes. They will be disposed of with respect.
- g. The likelihood of a blood transfusion, and the risks, benefits, and alternatives to the transfusion of blood or blood products has been discussed with me. Blood or blood products may be used as necessary if related to this procedure.
- h. The need for tissue or other biologic material has been discussed with me. Tissue or biologic materials may be used as needed if related to this procedure.
- i. I have informed the Physician or other authorized provider of any changes to the condition of my child since the history and physical examination was performed.

7. I confirm my understanding of the procedure by:

- a. Repeating back, using my own words, a basic description of what will be done today;
and
- b. Having my questions about the procedure answered.

8. The surgery or procedure recommended to treat or make a diagnosis of my child is:

_____.

9. My questions have been answered. I agree to the procedure. Additional instructions are:

_____.

Signature (Patient/parent/legal guardian) Date Time

Witness (Phone consent/emergency surgery) Date Time

Name of Interpreter Language/ Organization Time

I met with and explained to the patient/parent/legal guardian the indications for performing the stated procedure, its benefits, potential risks, and alternatives, and likely consequences if it is not performed. The parent or guardian has confirmed their understanding of what they have been told by repeating back in their own words a basic description of what will be done.

I have also reviewed the patient's history and physical examination and have examined the patient to the extent needed and have determined that there are no changes that have occurred in the patient's condition since the history and physical examination was completed that might be significant for the patient's planned course of treatment, except for the changes documented here:

Physician/ or Other Authorized Provider Date Time

I acknowledge that I explained to the patient/family the plan for anesthesia/sedation, its risks, benefits, and other options.

Anesthesiologist/Sedation Physician or Practitioner Date Time

Parent not available, see note in chart.

PLACE PATIENT LABEL HERE