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| **English**  |  |
| I acknowledge that the physician or designee has explained to me that the oral, intravenous, or intranasal sedation drugs will be given to reduce the fear, anxiety or pain associated with the procedure or to limit physical activity. |  |
| The alternative(s) to the use of sedation drugs, including the ability to not use them, as well as the advantages and disadvantages of each alternative have also been explained to my satisfaction. |  |
| In addition, I acknowledge that the known risks and benefits of receiving sedation drugs as well as the objectives of sedation and the anticipated changes in behavior using and following sedation have been fully explained to me. |  |
| I acknowledge that all questions I have asked concerning sedation have been answered to my satisfaction and that all blank spaces were completed prior to my signing this form. |  |
| I understand the information, which has been provided to me, and wish for me or my child to receive sedation drugs for the noted procedure(s). |  |
| [1]I further understand that the major risks and/or complications of the procedure listed above are (the major risks include but are not limited to anesthesia, if required, failure to obtain the desired result(s) of the procedure, discomfort, injury, the need for additional therapies, permanent loss of body function and death): |  |
| I acknowledge that all questions I have asked concerning the above listed procedure have been answered to my satisfaction and that all blank spaces were completed prior to my signing this form. |  |
| I understand the information, which have been provided to me and wish for me or my child to have the above procedure performed and hereby give my informed consent for CCHMC and Dr. |  |
| Informed Consent for Procedure is signed and coincides with scheduled procedure and physician order as necessary. |  |
| Verbally verify procedure with patient/family/authorized responsible person. |  |
| Procedure site is marked and initialed by the proceduralist. |  |
| Verify that ordered pre-procedure labs and diagnostic studies have been completed. |  |
| Before agreeing to a blood product transfusion for me/my child, it is important that I discuss the needs, risks and benefits with my/my child’s physician. |  |
| For more information, I have been given a pamphlet that discusses these items and choices other than blood product transfusions. |  |
| I understand that no guarantee or promise can be made regarding the results of the transfusion therapy. |  |
| I understand that in an emergency situation, the person caring for me/my child may have to give blood products immediately without my express permission. |  |
| I am aware that I should always discuss any planned transfusion with the physician ordering the transfusion and/or my/my child’s physician to be sure that I understand the need for the transfusion. |  |
| I have had the chance to ask questions. |  |
| By signing, I confirm to the best of my knowledge that the law allows me to consent to the procedure(s) for this patient. |  |
| Please answer all items as completely as possible prior to transferring a patient to Cincinnati Children’s Hospital Medical Center (CCHMC). |  |
| Please leave copies of the patient’s medical record and x-rays ready for transport. |  |
| When transporting a neonate, include a copy of the mother’s medical record. |  |
| Prepare the placenta and cord blood for transport with the neonate. |  |
| To protect the rights and honor the wishes of our patients and their parents/legal guardian(s), CCHMC must be aware of the name, relationship and telephone number of the patient’s parent/legal guardian. |  |
| Except in emergency situations determined by our medical staff or when the patient is legally permitted to consent to his/her own treatment, the patient’s parent/legal guardian must authorize hospitalization and any special procedures. |  |
| Any minor patient must be discharged to the person with legal custody or to someone specifically so authorized by the legal guardian.[1] |  |
| I am the person named above and I am the legal guardian of the patient identified on this form by virtue of |  |
| do hereby authorize Children’s Hospital Medical Center Transport Team to transport my child and have my child admitted if necessary upon arrival. |  |
| For those patients being treated at CCHMC, I authorize CCHMC and the doctor(s) participating in the care of my/our child to use any treatment or procedures that may be deemed necessary in the medical or dental care and that may be reasonably expected to be part of the normal inpatient or outpatient service. |  |
| This shall include the use of drugs, medicines, laboratory procedures, X-ray procedures and diagnostic testing (whether performed at CCHMC or at nearby facilities), immunizations, preventive medicine procedures, routine recreational activities, and the use of local anesthesia during laboratory procedures and diagnostic testing. |  |
| This consent for treatment does not authorize any type of surgical or medical procedure requiring the routine use of general anesthesia or sedation. |  |
| I understand that during the diagnostic or treatment process, the medical team may determine that it is in the best interest of my child to refer him/her to other services within CCHMC. |  |
| I authorize such transfer and treatment. |  |
| This authorization shall allow the doctors to provide continuing services until revoked by me in writing. |  |
| For patients receiving care in the shock/trauma suite, I authorize CCHMC and their physicians to take video/audio recordings of me/my child or part of my/my child’s body while under the care of the hospital. |  |
| These images can only be used for medical education or performance improvement. |  |
| Images obtained for either purpose will be destroyed after 30 days. |  |
| This consent also includes confidential testing for the blood-borne infectious diseases hepatitis B and hepatitis C in the event that a healthcare provider is exposed to my or my child's blood or body fluid while providing care for me or my child. |  |
| Assignment of Benefits and Release of Information (Financial Responsibility) |  |
| I hereby authorize payment to the hospital and physician rendering the services described herein. |  |
| I understand I am responsible to the hospital and physician for charges not covered by my insurance company for services provided under this authorization. |  |
| If a referral from my insurance company is required for payment to be made, I assume responsibility for obtaining this referral and for all charges associated with this account if no referral is obtained. |  |
| If this account becomes delinquent (not paid in full within 90 days of the last date of service through no fault of CCHMC) and is forwarded to a collection agency, I agree to pay the ten dollar ($10) charge per account. |  |
| I also authorize CCHMC and any treating physician to release any and all information related to the care and treatment of the patient that may be requested or required by the third party payer (insurance company, government agency or its respective agents, or employer), to the extent necessary to secure payment. |  |
| I further authorize the release, to the extent necessary, of information from my child’s medical record to appointees of the CCHMC medical staff, its allied health professionals, employees and other agents, as well as to accrediting and licensing/regulatory entities who have, in turn, agreed to keep such information confidential, for the purpose of reviewing or auditing the performance of CCHMC, its medical staff, its allied health professionals, its employees and/or agents otherwise assisting CCHMC in the rendering of medical care or the performance of other health care operations. |  |
| This authorization includes the release of information concerning HIV testing, diagnosis or treatment of AIDS, AIDS-related conditions, drug/alcohol abuse, drug-related conditions, and/or psychiatric/psychological diagnosis and treatment. |  |
| A.[1]I understand that consent has not yet been obtained from the parents or legal guardian for the above named patient. |  |
| However, I believe that treatment [1}is {2]medically necessary for this individual at this time in order not to jeopardize his/her well-being or to contribute to the deterioration of his/her condition. |  |
| Physician Signature/Credentials[1]Time/Date[1]Pager # |  |
| B.[1]I understand that consent has not yet been obtained from the parents or legal guardian for the above named patient. |  |
| I understand that the licensed provider(s) may find unexpected conditions during the procedure(s) named above. |  |
| An unexpected condition may require a change in procedure. |  |
| I give my permission for the licensed provider(s) identified on this form to either [1}extend{2] the planned procedure (do more) or do a [3}different{2] procedure, if she/he believes it is medically necessary for my health / health of the patient. |  |
| I understand that Cincinnati Children’s Hospital Medical Center is a teaching hospital. |  |
| One of the activities of the hospital is training licensed providers, nurses, and other health care providers. |  |
| Interns, residents, nurses, medical students and other health care workers may assist in the procedure under my licensed provider’s direct supervision. |  |
| I give my permission for this assistance. |  |
| [1]My questions about the procedure(s) have been answered to my satisfaction. |  |
| [1][2}I also understand that if I have more questions at any time before the procedure(s), I can call my doctor’s office at{3] |  |
| 4.[1]I understand that Cincinnati Children’s Hospital Medical Center is a teaching facility and that residents, fellows, or students may assist with or carry out parts of the anesthetic care or other medical acts as considered appropriate by, and under the direction of the attending anesthesiologist. |  |
| I give my permission for this assistance. |  |
| 5.[1]It has been explained to me and I understand that anesthesia care is often provided by a team that includes an anesthesiologist and certified registered nurse anesthetist. |  |
| A nurse practitioner may perform a history and physical, anesthesia evaluation and order medications for me/the patient to take before surgery. |  |
| All members of the Anesthesia Care Team work within their scope of practice as outlined by Ohio law and for which they have been granted privileges. |  |
| 6.[1]I understand that the Anesthesia Care Team may find unexpected conditions while monitoring and giving anesthesia. |  |
| I give my permission for the anesthesiologist to change the anesthesia and monitoring if they feel it is medically necessary for my health/ or the health of patient. |  |
| 7.[1]My questions about anesthesia and monitoring have been answered to my satisfaction before my/the patient’s procedure. |  |
| I have read and understand this consent form and all of the above blanks were filled in before I signed it. |  |
| By signing, I confirm to the best of my knowledge that the law allows me to consent to the anesthesia and monitoring for myself/the patient. |  |
| TO BE USED WHEN BLOOD TRANSFUSION IS REFUSED |  |
| My/my child’s physician has discussed with me the plan of treatment. |  |
| I understand the purpose, procedures, benefits, and risks associated with this surgical procedure. |  |
| The medical staff acknowledges my/my child’s desire to forgo blood transfusion as a form of medical care during my/my child’s time at Cincinnati Children’s Hospital Medical Center. |  |
| I understand the risks and consequences of not receiving blood transfusion as a form of treatment and choose to still refrain from accepting this form of care. |  |
| Stated below are the medical management therapies that I have identified to be used in place of blood transfusion. |  |
| I understand and acknowledge that in the event of an emergency, and if bloodless alternatives have been exhausted or impracticable, my physician will intervene medically or seek a Court Order to prevent the risk of death or serious harm as required by state law. |  |
| Check only one choice |  |
| Proteins produced by the immune system that help the body defend against bacteria, viruses, and other foreign agents. |  |
| Direct a patient’s immune system to attack viruses, bacteria, tumors and other foreign substances that infect the body |  |
| I accept procedures/treatments involving the use of my/my child’s own blood |  |
| I refuse any procedures/treatments involving the use of my/my child’s own blood |  |
| I accept procedures/treatments involving the use of my/my child’s own blood with the exception of: |  |
| Procedures Involving the Use of Patient’s Blood |  |
| ACUTE NORMOVOLEMIC HEMODILUTION (ANH) |  |
| After the patient is under anesthesia a predetermined amount of blood is removed from the patient |  |
| IV fluid is added to the blood to increase blood volume. |  |
| (No preservatives are added to the blood) |  |
| Blood will be returned to the patient within 8 hours otherwise the blood is thrown away (Blood may be returned during surgery or in the recovery room) |  |
| BLOOD SALVAGE/CELL SALVAGE |  |
| [1}In the Operating Room{2][3]: |  |
| Blood that enters the surgical field or wound is collected, filtered, and/or washed, the red cells are returned to the patient either in the operating room or in the recovery room[1] |  |
| To protect the rights and honor the wishes of our patients and their parents/legal guardian(s), Cincinnati Children’s Hospital Medical Center must be aware of the name, relationship and telephone number of the patient’s parent/legal guardian. |  |
| Except in emergency situations determined by our medical staff or when the patient is legally permitted to consent to his/her own treatment, the patient’s parent/legal guardian must authorize hospitalization and any special procedures. |  |
| [1][2}Patients should be discharged only to an appropriate individual pursuant to the Medical Center Policy entitled Persons Authorized to Consent for Admission, Treatment and Discharge of Patients.{3] |  |
| CONSENT FOR MEDICAL TREATMENT |  |
| For those patients being treated at Cincinnati Children’s Hospital Medical Center (CCHMC), I authorize CCHMC and the doctor(s) participating in the care of my/our child to use any treatment or procedures that may be deemed necessary in the medical or dental care and that may be reasonably expected to be part of the normal inpatient or outpatient service. |  |
| This shall include the use of drugs, medicines, laboratory procedures, X-ray procedures and diagnostic testing (whether performed at CCHMC or at nearby facilities), immunizations, preventive medicine procedures, routine recreational activities, and the use of local anesthesia during laboratory procedures and diagnostic testing. |  |
| This consent for treatment does not authorize any type of surgical or medical procedure requiring the use of general anesthesia or sedation. |  |
| I understand that during the diagnostic or treatment process, the medical team may determine that it is in the best interest of my child to refer him/her to other services within CCHMC. |  |
| I authorize such transfer and treatment. |  |
| This authorization shall allow the doctors to provide continuing services until revoked by me in writing. |  |
| For patients receiving care in the shock/trauma suite, I authorize CCHMC and their physicians to take video/audio recordings of me/my child or part of my/my child’s body while under the care of the hospital. |  |
| These images can only be used for medical education or performance improvement. |  |
| Images obtained for either purpose will be destroyed after 180 days. |  |
| ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION (FINANCIAL RESPONSIBILITY) |  |
| In consideration of services rendered, I authorize payment to Cincinnati Children's Hospital Medical Center for all hospital, physician/professional, and ancillary services rendered, and I assign to CCHMC all right, title, and interest in and to any third party benefits due from any and all insurance policies, employee benefit plans, and/or responsible third party payers in an amount not to exceed CCHMC's regular and customary charges for services rendered. |  |
| I accept responsibility for determining whether services provided to me are covered by my insurance or other third-party payer, and I understand that I am responsible to CCHMC for charges not covered by my insurance company for services provided. |  |
| If a referral from my insurance company is required for payment to be made, I assume responsibility for obtaining this referral and for all charges associated with this account if no referral is obtained. |  |
| I consent to any request for review or appeal by CCHMC to challenge a determination of benefits made by a third-party payer, insurance carrier, or employee benefit plan. |  |
| I also authorize CCHMC and any treating physician to release any and all information related to the care and treatment of the patient that may be requested or required by the third party payer (insurance company, government agency or its respective agents, or employer), to the extent necessary to secure payment. |  |
| I further authorize the release, to the extent necessary, of information from my child's medical record to appointees of the CCHMC medical staff, its allied health professionals, employees and other agents, as well as to accrediting and licensing/regulatory entities who have, in turn, agreed to keep such information confidential, for the purpose of reviewing or auditing the performance of CCHMC, its medical staff, its allied health professionals, its employees and/or agents otherwise assisting CCHMC in the rendering of medical care or the performance of other health care operations. |  |
| Patient information may be stored electronically and used to improve clinical outcomes. |  |
| This authorization includes the release of information concerning HIV testing, diagnosis or treatment of AIDS, AIDS-related conditions, drug/alcohol abuse, drug-related conditions, and/or psychiatric/psychological diagnosis and treatment. |  |