DOCUMENTATION OF INFORMED CONSENT

Patient's Name: ____
Responsible Practitioner: ____
Procedure/Treatment/Test:____
____
____
____

The risks, benefits, and anticipated outcomes of the procedure/treatment/test (the "patient's procedure" or "my procedure"), the alternatives to the patient's procedure and the risks and benefits of those alternatives, and the roles and tasks of the personnel to be involved in the patient's procedure, were discussed with the patient or the patient's representative in understandable terms and they verbalized understanding.

______________________________	______________________	________________	_________
Practitioner Signature	*Practitioner Printed Name*	*Date Signed*	*Time*

1. **I, the patient or personal representative, have talked with my doctor or healthcare team about:**
   a. My medical condition, my procedure, why I am having it done, and what will happen during and after my procedure, including the possible need for blood or blood products and the possible risks.
   b. How my procedure may help me (the benefits).
   c. How my procedure might harm me (the most common and any serious risks, complications, and side effects).
   d. The equipment my practitioner deems appropriate for my procedure with the goal of the best possible outcome, to the extent that information is significant to my decision making.
   e. My other options for treatment and the risks and benefits of those options.
   f. What will likely happen if I don't have this procedure/treatment/test.
2. **I, the patient or personal representative, understand that:**
   a. I can change my mind. If I do, I must tell my practitioner or team as soon as possible and before the procedure begins.
   b. My practitioner may change my procedure, if doing so is best for me. For example, if my practitioner finds a serious problem or if complications arise during the procedure.
   c. Caregiver training may occur during my procedure and I understand that any of my care performed by a trainee will be performed under the supervision of my doctor and healthcare team.
   d. No promise is made to me concerning a result, outcome, or cure.
   e. I am cared for by a team led by my attending practitioner. I understand that my attending practitioner may leave the procedure room and/or be involved in another procedure at certain non-critical portions of my procedure while members of the team continue to perform non-critical portions of my procedure under my practitioner's direction.
   f. Tissues that are removed from my body may be examined, stored and/or disposed of.

My questions have been answered to my satisfaction and in terms I understand. I accept the risks and agree to the procedure/treatment/test.

Signature of patient or person authorized to give consent ______________________________ Date _________ Time _______

Relationship to the patient ____

Witness to the above signatures ____Date___________Time________
(Required by Critical Access Hospitals: Delta Community, Fillmore Community, Heber Valley, Sanpete Valley, Cassia Regional and Garfield Memorial)

Telephone or Verbal Consent	
	________________________________ ________________ ________________ **Name of Person Giving Consent** **Relationship** **Phone Number** **Witness to Telephone/Verbal Consent_________________________ Date _____________ Time ______**

Intermountain Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
我們將根據您的需求提供免費的口譯服務。請找尋工作人員協助
Se proveen servicios de interpretación gratis. Hable con un empleado para solicitarlo.

Interpreter's name and Interpreter agency (if applicable) _________________________ _________________________
Interpreter Printed Name *Interpreter Agency*

AFFILIATE / OFFICE INFORMED CONSENT
(Critical Access Hospitals)

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