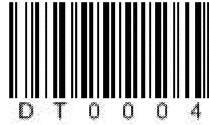
THE UNIVERSITY
OF KANSAS HOSPITAL
3901 Rainbow Boulevard
Kansas City, Kansas 66160




Patient Label

# DOCUMENTATION OF INFORMED CONSENT

1. My physician and I have discussed my condition and his/her recommended treatment. No guarantees or promises have been made to me that the recommended treatment or operation will improve my condition.

2. I understand my physician believes I have the following condition: ______________________________ and that the recommended treatment or procedure is: ☐ **Left** ☐ **Right** ☐ **NA**

______________________________________________________________________________

______________________________________________________________________________

3. My physician has explained to me the purpose of this treatment or procedure and how it is generally carried out. My physician has also explained other ways of treating my condition, including no treatment or procedure, and the risks and benefits of the alternatives. I have decided to have the treatment or procedure described in paragraph 2.

4. I understand that all operations involve general risks such as bleeding, infection, allergic reaction, problems with my heart or blood pressure and even death. My physician has explained these general risks and specific risks and possible side effects of this treatment or procedure, described in paragraph 2, including:
______________________________________________________________________________.

5. I understand The University of Kansas Hospital is a teaching hospital and that, under the supervision of my physician, resident physicians and other learners may be observing or assisting in my treatment or procedure and may assist in opening and closing, dissecting tissue, and/or removing tissue. I also understand that nurses and other health care workers will be caring for me during my treatment or procedure.

6. I agree to administration of anesthesia under the direction of the staff anesthesiologist, as he or she believes advisable for the operation or procedure I am having.

7. My physician has explained that sometimes during an operation it is discovered that additional surgery is needed immediately. If I need such additional surgery during my operation, I permit my physician to proceed.

8. I agree that anything removed from me during the treatment or operation may be used for teaching or diagnosis or disposed of by the hospital as usual.

9. I have had the chance to ask questions and my questions have been answered to my satisfaction.

**I give permission for Dr.______________________________________ to perform the recommended treatment or procedure described in paragraph 2.**

| ______________________ | ______________________ | __________ | __________ |
|---|---|---|---|
| Print name of physician informing patient | Signature of physician informing patient | Date | Time |
| | ______________________ | __________ | __________ |
| | Patient Signature | Date | Time |
| ______________________ | ______________________ | __________ | __________ |
| Print name of person with authorization to consent for patient | Signature of person with authority to consent* | Date | Time |
| ______________________ | ______________________ | __________ | __________ |
| Witness/validated by: print name | Signature of witness/validator | Date | Time |

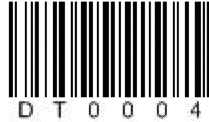
Interpreting services: Interpreted/sight translated by______________________ __________ __________
(Circle one) Interpreter Signature Date Time

Print Interpreter name:______________________________

* Patient is unable to sign because: ______________________________



DOCUMENTATION OF INFORMED CONSENT

| THE UNIVERSITY OF KANSAS HOSPITAL<br>3901 Rainbow Boulevard<br>Kansas City, Kansas 66160 | Do not write in this box<br> | PATIENT LABEL |
|---|---|---|

# INFORMED DECISION-MAKING - BLOOD, BLOOD PRODUCTS

1. My physician and I have discussed my condition and his/her recommended treatment with blood or blood products. No guarantees or promises have been made to me that the recommended treatment will improve my condition.

2. My physician has explained to me the nature and purpose of the administration of blood and/or blood products and how the administration is generally carried out. My physician has also explained other ways of treating my condition and the risks associated with those alternatives.

3. The risks and benefits of receiving blood or blood products have been explained to me, and I understand those risks and benefits. My questions have been answered to my satisfaction.

4. I understand that there are risks and adverse reactions associated with blood transfusions and that my physician believes the benefits outweigh the risks and that transfusion is necessary and medically desirable. I am aware risks and adverse reactions include:

HIV: 1 in 2,500,000 units of transfused blood
Hepatitis C Virus: 1 in 2,000,000 units
Hepatitis B Virus: 1 in 100,000
West Nile Virus: 1 in 1,400,000 units
Bacterial contamination: 1 in 15,000 units for platelets, 1 in 75,000 units for red cells
Other infectious and non infectious adverse reactions include circulatory overload, depressed red cell production, acute lung injury, allergic reactions, fever, hemolytic transfusions reactions, and graft vs. host disease.

☐ **Accept** blood or blood products. My physician has talked with me about when I may need blood, and the risks, benefits and alternatives to receiving blood. I understand these risks and benefits and my questions have been answered to my satisfaction. I understand I can accept blood and blood products or refuse to accept blood or blood products.

☐ **Refuse** blood or blood products. I request that **no** blood or blood products be administered to me at any time, under any circumstances, during the course of my treatment. It is my desire and intent that blood or blood products **not** be used in any effort to preserve my life, whether or not my condition may deteriorate or I may die. I understand that the administration of blood or blood products may be considered necessary in the opinion of my physician and have been fully informed of the risks and possible consequences of my decision. I release my physician and treatment team at The University of Kansas Hospital from any and all liability for any deterioration of my health condition caused by my refusal of recommended blood or blood products.

5. I understand that I can change my mind about any part of this treatment plan at any time. If I change my mind, I will be asked to complete a new form in order to document my wishes. This signed document is valid throughout the course of treatment described above, until my treatment plan changes, my condition changes unexpectedly or until I change my mind.

| ______________________ | ______________________ | __________ | __________ |
|---|---|---|---|
| Print name of physician informing patient | Signature of physician informing patient | Date | Time |
| | ______________________ | __________ | __________ |
| | Patient Signature | Date | Time |
| ______________________ | ______________________ | __________ | __________ |
| Print name of person with authorization to consent for patient | Signature of person with authority to consent* | Date | Time |
| ______________________ | ______________________ | __________ | __________ |
| Witness/validated by: print name | Signature of witness/validator | Date | Time |

Interpreting services: Interpreted/sight translated by______________________ __________ __________
(Circle one) Interpreter Signature Date Time

Print Interpreter name:______________________________

* Patient is unable to sign because: ______________________________



INFORMED DECISION-MAKING - BLOOD, BLOOD PRODUCTS