Salem Health
Informed Consent

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Patient Name:______________________ **Date of Birth:** _____ / _____ / _____

Name of Procedure(s) (*Do Not Use Abbreviations*) ______________________

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Dr. ______________________ will perform the procedure(s). Other practitioners may assist with the procedure(s) as necessary.

The physician/credentialed provider has explained the procedure(s), the anticipated benefits, risks and alternatives to me, and I understand the risks involved. I had the opportunity to ask questions and all of my questions about the procedure(s), risks and alternatives were answered to my satisfaction. I understand that, during the course of the procedure(s), unforeseen conditions may necessitate additional or different procedures than those listed above or discussed with me. I authorize the physician/credentialed provider and/or other practitioners to perform such other procedures as are, in their judgment, necessary and appropriate. I acknowledge that no warranty or guarantee was made to me as to result or cure.

It was also explained to me that there are possible risks involved with blood/blood product transfusion. I understand these risks and consent to the administration of blood/blood products if medically necessary and ordered by my physician.

☐ I refuse administration of part or all blood and blood products as documented on the Refusal of Blood Transfusions Release of Liability Form.

In the event that my treatment involves the implanting of a medical device, I authorize the release of information involving the procedure and any patient identification information required for medical device tracking purposes in accordance with federal and state law and regulations.

I authorize the use of x-rays, imaging studies, lasers, photographs or other modalities of treatment or documentation as determined appropriate by my physician.

I authorize Salem Health, in the manner it routinely follows, to dispose of any tissue or body parts removed except:

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Authorized healthcare students may be assisting or performing parts of the procedure under direct supervision of my physician.

I CONSENT TO THE ABOVE PROCEDURE(S)

Patient's Signature	**Printed Name**	/ / **Date**	: ☐ a.m. ☐ p.m. **Time**

*Patient is unable to consent because: ______________________ . I therefore consent for the patient.

Authorized Consenter's Signature	**Printed Name**	/ / **Date**	: ☐ a.m. ☐ p.m. **Time**
Witness' Signature	**Printed Name**	/ / **Date**	: ☐ a.m. ☐ p.m. **Time**

☐ Mark this box if Telephone Consent (*2nd witness signature required*)

2nd Witness' Signature	**Printed Name**	/ / **Date**	: ☐ a.m. ☐ p.m. **Time**
Interpreter's Signature if applicable	**Printed Name**	/ / **Date**	: ☐ a.m. ☐ p.m. **Time**

PATIENT LABEL