Adventist Health Tillamook

Patient Informed Consent

Important: Sign only in one place after carefully reading entire form.

Patient: _____

_____ (name of physician) has explained to me in a way that I understand:

1. The general procedure or treatment to be undertaken: _____
   _____
   _____
2. There may be other procedures or methods of treatments; and _____
3. Specific risks for this procedure include the following: _____
   _____

SIGN IN THIS BOX ONLY IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment. I give my permission and consent to the procedure or treatment.

_____ _____
Date Patient's signature

Signature: _____ Date: _____

Print name: _____ Time: _____ am/pm

Witness: _____ Date: _____

Print name: _____ Time: _____ am/pm

Physician documentation of informed consent (required prior to incision or initiation of operations/procedures except in an emergency): I, the undersigned physician, hereby certify that I have discussed the procedure above with this patient or other legally responsible person, including the risks and benefits of the procedure any adverse reactions that may reasonably be expected to occur, any alternative efficacious methods of treatment which may be medically viable and any research or economic interest I may have regarding this treatment. I further certify that the patient was encouraged to ask questions and that all questions were answered.

_____ _____
Provider signature Date Time

_____
Provider printed name

Adventist Health Tillamook

IDENTIFICATION OF PRACTITIONER(S) PERFORMING SIGNIFICANT SURGICAL TASKS

Name of patient: _____ Patient ID #: _____

Name of procedure(s): _____ Date of procedure: _____

Primary surgeon: _____

First assist: _____

The Centers for Medicare and Medicaid Services require that you be informed of the name of each practitioner(s) performing significant surgical tasks during your operation. "Significant surgical tasks" include, but are not limited to, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissues. If a resident physician will be performing any significant surgical tasks, only "resident" must be indicated, rather than the resident's name.

I have been informed that the following practitioner(s) will be performing the following significant surgical tasks:

_____

_____

_____

I understand and agree that if the practitioner(s) named above is unable to perform or complete the task, a substitute practitioner may do so, and that this information will be recorded in my medical record. I understand that the practitioner(s) named above are not employees of agents of the hospital. They are independent contractors.

Signature: _____ Date: _____
Patient/Parent/Conservator/Guardian

Print name: _____ Time: _____ am/pm
Patient/Parent/Conservator/Guardian

If signed by other than patient, indicate name and relationship: _____

_____

Witness: _____ Print name: _____

I, the undersigned physician, hereby certify that I have discussed with the patient, or the patient's legal representative, the role and responsibility of each practitioner performing a significant surgical task. I encouraged the patient to ask questions and all questions were answered.

_____ _____
Provider signature Date Time

_____
Provider printed name

Consent/Refusal/ Request/Release

{ Patient label }

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