Saint Alphonsus
A Member of Trinity Health

AFFIX PATIENT LABEL OR WRITE
Patient's Name: _____
Date of Birth: _____
Today's Date: _____
OFFICE USE ONLY

Surgical/Procedural Informed Consent -- SAHS-411

Patient's Name: _____ Date of Birth: ____/____/____

Provider Name: _____

Facility: ☐ Baker City ☐ Boise ☐ Nampa ☐ Ontario ☐ Clinic: _____

Procedure(s) *(no abbreviations)*:

_____

_____

_____

_____

MEDICAL CONDITION AND PROCEDURE: My medical provider has discussed my medical condition with me, as well as the procedure identified above. I understand what is involved in this procedure, including that I may need to receive anesthesia, sedation, or both. Risks and side effects associated with anesthesia or sedation will be discussed with me and I may be asked to sign a separate consent regarding anesthesia or sedation prior to my procedure. I also understand that I have the right to refuse this procedure.

RISKS: I understand that all medical procedures involve risks, which may range from minor discomfort to allergic reactions, bleeding, blood clots, heart attack, infection, injury to surrounding areas, nerve injury, respiratory failure, kidney failure, severe blood loss and stroke. My medical provider has discussed with me specific known risks associated with this medical procedure. If any of these risks occur, their treatment may require additional procedures. These risks can be serious and possibly fatal. I understand and freely assume these risks.

Additional Risks (if any): _____

ALTERNATIVES: My medical provider has explained to me the alternatives to this procedure, including the risks and benefits of these alternatives. Examples of alternatives include monitoring or no treatment, which may have serious consequences.

Additional Alternatives (if any): _____

BENEFITS: My medical provider has discussed with me the possible benefits associated with this procedure. I understand that there is no certainty that I will achieve these benefits. No guarantees have been made to me regarding the outcome of this procedure.

Benefits of the Procedure May Include: _____

After being informed of the risks, benefits, and alternatives to the procedure identified above, I choose to have the procedure.

CARE TEAM: I authorize my medical provider identified above to perform this procedure. I understand that he or she will be assisted by a care team that may include: anesthesia providers, nurses, technicians, and medical device specialists. This team may also include other attending surgeons, residents, fellows, medical students and advanced practice professionals. I authorize such individuals to perform portions of the operation or procedure that is within their scope of practice and under the direction of the medical provider identified above.

Blood or Blood Product Administration

☐ Check here if blood administration is not anticipated for this procedure

It has been explained to me that I need or may need blood or blood product transfusion(s). I understand in general, what a transfusion is and the procedures that will be used. I understand that my provider will decide the amount and type of blood product needed based on my particular needs.

BENEFITS: Blood and blood products are therapeutic agents derived from human blood that support blood oxygen carrying capacity, fight infection, prevent shock and stop bleeding. Transfusions may be needed to replace blood lost by injury, to replace abnormal blood, or to raise the blood count when the body is not able to produce enough blood cells on its own.

RISKS: I understand that there is a small but definite risk of potentially serious infectious disease transmission and/or other reactions. The diseases include, but are not limited to, hepatitis, acquired immune deficiency syndrome (AIDS), and West Nile Virus. Other adverse reactions may include, but are not limited to, the symptoms of fever, chills, hives, or in more severe reactions, the possible destruction of the transferred red cells, immunization, bacterial infections and rarely, death.

ALTERNATIVES: There is no effective alternative to blood or blood transfusion(s). If no blood or blood product is given, the problem that it was intended to treat may persist and potentially result in death. In the case of elective transfusion, alternatives to receiving blood from the community blood supply include the pre-donation of one's own blood (autologous blood donation). Autologous donations must be collected several days to weeks prior to use and directed donations require several days to process.

☐ I **DO** consent to the administration of any and all blood and/or blood products as ordered by my provider.

☐ I **DO NOT** consent to the administration of any and all blood and/or blood products as ordered by my provider.

If patient or representative does not consent to any and all blood or blood product administration, complete Informed Refusal of Blood Products & Blood Fractions--SAHS1096

By my signature below, I confirm that: (i) my medical provider has explained the above information to me, answered all of my questions, and provided a more detailed explanation if I requested it; (ii) I understand the above information; (iii) I consent to my medical provider performing the procedure identified above; and (iv) if indicated above, I consent to the administration of any and all blood and/or blood products as ordered by my medical provider.

I understand that unforeseen conditions may arise during the procedure, which, in the judgment of my medical provider, may require additional or different procedures and/or treatments. In such event, I hereby authorize my medical provider to do whatever he or she, in his or her professional medical judgment, considers medically to be in my best interest. I further understand and agree that this document is in addition to, and not in replacement of, my *Consent for Medical Care and Patient Services Agreement* and any other consent that I execute.

_____ _____ _____

Signature of Patient **Date** **Time**

The patient is unable to sign because _____

For this reason, I give consent to the procedure and blood/blood product administration (if indicated above) on behalf of the above-named patient.

_____	_____	_____	_____
Signature of Patient's Representative	**Relationship to Patient**	**Date**	**Time**

Interpreter Services:

___Telephonic interpreter ___Video-remote interpreter ___In-person interpreter

_____	_____	_____	_____
Interpreter's Name	**Signature and/or ID#**	**Date**	**Time**

The signature of the Witness signifies: (i) the Witness confirmed the Patient (or the Patient's Representative, as applicable) has no further questions for the medical provider; and (ii) the Witness either observed the Patient/Patient Representative execute this form or verbally confirmed with Patient/Patient Representative that the respective signature on this form is Patient's/Patient Representative's signature.

Witness: _____	_____	_____
Signature	**Date**	**Time**

By signing this form, the medical provider confirms that, prior to the procedure being performed, he or she has: (i) explained the above procedure information and blood/blood product information (if applicable); (ii) received the Patient's or Patient Representative's informed consent to the procedure; and (iii) if indicated above, received the Patient's or Patient Representative's informed consent to blood/blood product administration; OR

☐ Emergency Consent: Medical provider reasonably concludes there is a substantial likelihood of the Patient's life or health being seriously endangered by a delay in the procedure and the Patient/Patient Representative cannot provide informed consent.

Medical Provider: _____	_____	_____
Signature	**Date**	**Time**

(Office Staff only):
Patient Name (Last, First):
Date of Birth:

Non-Discrimination Notice

Saint Alphonsus Health System, Inc. honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression).

Saint Alphonsus Health System, Inc.:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic and other formats
- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Community Services Coordinator at 1-866-727-6248.

If you believe that Saint Alphonsus Health System, Inc. has failed to provide these services or discriminated in another way on the basis of age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression), you can file a grievance in person, by mail, fax or email to:

- Patient Relations Coordinator
  1055 N Curtis Road, Boise, Idaho 83706
- Phone: 208-367-6226 I Fax: 208-367-8181
- Email: BO-PatientRelations@saintalphonsus.org

If you need help filing a grievance the Patient Relations Coordinator is available to help you. You can also file a civil rights complaint with the US Department of Health & Human Services, Office for Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Service 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201
- Web: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1-800-368-1019 I TTY 1-800-537-7697

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Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الترجمة اللغوية تتوافر لك بالمجان.
اتصل بالرقم: 1-866-727-6248 , (رقم هاتف الصم والبكم:1-844-801-7932)

Burmese

သတိ။ ။ သင် [ဗမာစကား] ပြောရင် ဘာသာစကားအတွက် အကူအညီပေးတဲ့ဝန်ဆောင်မှု အခမဲ့ရရှိနိုင်ပါတယ်။ 1-866-727-6248 TTY: 1-844-801-7932 ကို ဖုန်းဆက်ပါ။

Chinese

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-866-727-6248 TTY：1-844-801-7932。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 8426-727-668-1. 2397-108-448-1. تماس بگیرید.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-866-727-6248 ATS : 1-844-801-7932.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-866-727-6248 TTY: 1-844-801-7932 まで、お電話にてご連絡ください。

Karen

ဟ်သူဉ်ဟ်သး: မ့မ့်နတဲတၢ်ပှၤကညီကျိာ်အကိးလီတဲစိနိဉ်ဂ်ၢ် 8426-727-668-1 TTY: 2397-108-448-1. မၤစၢၤနၢ်သ့ဒီးစ့တလိဉ်ဘဉ်မ့အကလီ.

Kirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-866-727-6248 TTY: 1-844-801-7932.

Korean

안내: [한국어] 를 사용하시는 경우 언어 지원 서비스를 무료 이용하실수 있습니다. 1-866-727-6248 (TTY : 1-844-801-7932) 로 전화해 주십시요.

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-866-727-6248 दृष्टिविहीन: 1-844-801-7932 ।

Pashtu

خدمات مرستې وړيا ژبې د ،کوی خبرې ژبه پښتو په تاسو که :پاملرنه
ونیسی اړیکه شمیری دی په .دي چمتو ته تاسو

Romanian

Atentie: Daca vorbesti [Romania], serviciul de asistanta lingvistic, fara plata, este la indemana ta (disponibil). Suna la Telefonul acesta 1-866-727-6248 sau 1-844-801-7932

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-866-727-6248 телетайп: 1-844-801-7932.

Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-727-6248 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-844-801-7932.

Somali

DIGNIIN: Haddii aad ku hadasho [luqadda ku dar], adeegyada ka caawinta luqadda, oo lacag la'aan ah ayaa laguu heli karaa. Wac 1-866-727-6248 (TTY: 1-844-801-7932).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-727-6248 TTY: 1-844-801-7932.

Swahili

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-866-727-6248 TTY: 1-844-801-7932.

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال 1-866-727-6248 کریں 1-844-801-7932

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-866-727-6248 TTY: 1-844-801-7932.

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10 – 2022