Saint Alphonsus

SURGICAL/PROCEDURAL INFORMED CONSENT - SAHS-411

Patient 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.

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Patient Name: _____Date of Birth: _____

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, and (ii) I understand the above information and consent to my medical provider performing the procedure identified above. 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 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, medical provider confirms that he or she has explained the above procedure information and received the Patient's or Patient Representative's informed consent prior to the procedure being performed; 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): **Date of Birth:**
Patient Name (Last, First):

— Important Information —

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, race, color, national origin, age, disability, or sex.

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 race, color, national origin, age, disability or sex, 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 of Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Services, 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

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 အခမဲ့ရနိုင်ပါတယ်။ 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 8426-727-668-1. فراهم می باشد. با 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: မုမ့ါနတဲတၢ်ပှၤကညီကျိာ်ဒးကိးလီတဲစိနိဉ်ဂ်ါ် 8426-727-668-1 TTY: 2397-108-448-1. မၤစၢၤနါသ့ဒီးစ့တလိဉ်ဘဉ်မ့အကလီ.

Kirundi

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

Nepali

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

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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