CONSENT TO SURGERY OR SPECIAL PROCEDURE

1. Your doctors have recommended the following operation or procedure: _____

   _____

   and the following type of anesthesia: _____

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to an emergency or newly-discovered information, will be performed on you. The operations or procedures will be performed by the doctor named below (or in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of *(name of hospital)* _____

   ___ to whom the doctor(s) performing the procedure may assign designated responsibilities.

2. Name of the practitioner who is performing the procedure or administering the medical treatment[1]:

   _____

   The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, your doctors, surgeons, and the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not employees, representatives or agents of the hospital or of doctor(s) performing the procedure. They are independent medical practitioners.

3. All operations and procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

   - The nature of the operation or procedure, including other care, treatment or medications;
   - Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur with the anesthesia to be used and during recuperation;
   - The likelihood of achieving treatment goals;
   - Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
   - Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

   Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

1 CMS recommends that consent forms state, if applicable, that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies (and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner) and that qualified medical practitioners who are not physicians will perform important parts of the surgery or administration of anesthesia within their scope of practice, as determined under state law, and for which they have been granted privileges by the hospital.

4. If your doctor determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the various options for blood transfusion, including predonation by yourself or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait.

   Transfusion of blood or blood products involves certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV), and you have a right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your doctor.

5. By your signature below, you authorize the pathologist to use his or her discretion in disposition or use of any member, organ or tissue removed from your person during the operation or procedure set forth above, subject to the following conditions (if any): _____

   _____

6. Your signature on this form indicates that:

   - You have read and understand the information provided in this form;
   - Your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and alternatives, and the other information described above in this form;
   - You have had a chance to ask your doctors questions;
   - You have received all of the information you desire concerning the operation or procedure and the anesthesia; and
   - You authorize and consent to the performance of the operation or procedure and the anesthesia.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

PHYSICIAN CERTIFICATION[2]

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The risks and benefits of the procedure;
- Any adverse reactions that may reasonably be expected to occur;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
- The potential problems that may occur during recuperation; and
- Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 1. and 2. above. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(legal representative)

CONSENT TO BLOOD TRANSFUSION

Your signature below indicates that:

1. You have received a copy of the brochure, A Patient's Guide to Blood Transfusion.
2. You have received information from your doctor concerning the risks and benefits of blood transfusion and of any alternative therapies and their risks and benefits.
3. You have had the opportunity to discuss this matter with your doctor, including predonation.
4. Subject to any special instructions listed below, you consent to such blood transfusion as your doctor may order in connection with the operation or procedure described in this consent form.

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2 The Physician Certification is not a required element of this form but is one way of providing for physician documentation of the consent process. Other options include a progress note in the patient's medical record, a note in the patient's history and physical, or documentation provided from the physician's office (e.g., an informed consent form signed by both the patient and the physician). **NOTE:** Even if the physician provides a copy of a consent form signed in the physician's office, the patient should still be asked to sign the hospital's consent form.

Special Instructions: _____

_____

(Describe here any specific instructions for patient's blood transfusion, e.g., predonation, direct donation, etc.)

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to *(patient or patient's legal representative)* _____ in the patient's or legal representative's primary language *(identify language)* _____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____
(interpreter)

Print name: _____
(interpreter)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See "Taglines" on page 1.21, for detailed information.)*

Reference: CoP *Interpretive Guidelines*, Tags A-0466 and A-0955

CONSENTIMIENTO PARA EFFECTUAR CIRUGÍA O PROCEDIMIENTO ESPECIAL

1. Sus doctores han recomendado la siguiente operación o procedimiento: _____

   _____

   y el siguiente tipo de anestesia: _____

   Trassu autorización y consentimiento, se le realizará esta operación o procedimiento, junto con cualquier otroprocedimiento diferente o añadido que, en la opinión del médico o médicos que realizan el procedimiento pueda estar indicadodebido a una emergencia o nueva información. Las operaciones o procedimientos serán efectuados por el doctor o doctores que se nombran más abajo (o en caso de que alguno de estos doctores no pueda efectuar o completar el procedimiento, por un doctor sustituto calificado), junto a otros asociados y asistentes, entre ellos, anestesistas, patólogos y radiólogos del cuerpo médico *(nombre del hospital)* _____, a quienes el o los doctores que realicen el procedimiento podrían asignar responsabilidades designadas.

2. Nombre del médico que realiza la intervención o administra el tratamiento[1]: _____

   _____

   El hospital mantiene personal e instalaciones para ayudar a los doctores en el desempeño de las diferentes operaciones quirúrgicas y otros procedimientos terapéuticos o diagnósticos especiales. No obstante, sus médicos, cirujanos y las personas que asisten con el fin de prestar servicios médicos especializados, tales como anestesia, radiología o patología, no son empleados, representantes ni agentes del hospital ni del doctor o doctores que realizan el procedimiento, sino que son profesionales médicos independientes.

3. Todas las operaciones y procedimientos conllevan el riesgo de resultados fallidos, complicaciones, lesiones o incluso la muerte, tanto por causas conocidas como imprevistas, y no se otorga ninguna garantía respecto al resultado o la curación. Usted tiene derecho a que se le informe acerca de:

   - La naturaleza de la operación o procedimiento, incluidos otros cuidados médicos, tratamientos o medicamentos;
   - Los beneficios, riesgos o efectos secundarios potenciales de la operación o procedimiento, incluidos los problemas potenciales que podrían presentarse durante la recuperación por la anestesia utilizada;
   - Las alternativas razonables y los riesgos, beneficios y efectos secundarios pertinentes relacionados con dichas alternativas, incluidos los posibles resultados de no recibir atención o tratamiento, y
   - Cualquier interés en investigaciones médicas independientes u otros intereses significativos que su doctor pueda tener en relación con la realización de la operación o procedimiento propuesto.

   Excepto en casos de emergencia, las operaciones y los procedimientos no se efectúan sino hasta que usted haya tenido la oportunidad de recibir esta información y otorgar su consentimiento. Usted tiene

1 CMS recommends that consent forms state, if applicable, that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies (and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner) and that qualified medical practitioners who are not physicians will perform important parts of the surgery or administration of anesthesia within their scope of practice, as determined under state law, and for which they have been granted privileges by the hospital.

derecho a dar o rehusar su consentimiento para toda operación o procedimiento que se proponga en cualquier momento, antes de que éstos se efectúen.

4. Si su doctor determina que existe la posibilidad razonable de que usted requerirá una transfusión de sangre como resultado de la cirugía o procedimiento para el cual está otorgando su consentimiento, se lo informará y se le proporcionará información sobre los beneficios y los riesgos de las diversas opciones de transfusión de sangre, incluida la donación adelantada realizada por usted u otras personas. Usted también tiene derecho a contar con suficiente tiempo antes de su procedimiento para gestionar la donación adelantada, pero puede renunciar a este derecho si no desea esperar.

   La transfusión de sangre o derivados sanguíneos conlleva ciertos riesgos, incluyendo la transmisión de enfermedades como la hepatitis o el virus de la inmunodeficiencia humana (VIH), y usted tiene derecho a dar o rehusar el consentimiento para cualquier transfusión. Si tiene preguntas sobre las transfusiones, debe consultarlas con su doctor.

5. Por medio de su firma al pie, usted autoriza al patólogo a utilizar su propio juicio para la disposición o uso de cualquier extremidad, órgano o tejido que se obtenga de su persona durante la operación o procedimiento que se establece más arriba, sujeto a las siguientes condiciones (de haberlas):_____
   _____.

6. Su firma en este formulario indica que:

   - Leyó y entendió la información provista en este formulario;
   - Su doctor le explicó adecuadamente la operación o procedimiento y la anestesia que se utilizará, arriba mencionados, así como los riesgos, beneficios, alternativas y la otra información descrita en este formulario;
   - Tuvo oportunidad de hacerle preguntas a sus doctores;
   - Recibió toda la información que desea sobre la operación o procedimiento y la anestesia, y
   - Autoriza y otorga su consentimiento para la realización de la operación o procedimiento y la anestesia.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

PHYSICIAN CERTIFICATION[2]

I, the undersigned physician, hereby certify that I have discussed the procedure described in this consent form with this patient (or the patient's legal representative), including:

- The risks and benefits of the procedure;
- Any adverse reactions that may reasonably be expected to occur;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment;
- The potential problems that may occur during recuperation;
- The likelihood of achieving treatment goals; and
- Any research or economic interest I may have regarding this treatment.

I understand that I am responsible for filling in all blanks in paragraphs 1. and 2. above. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

CONSENTIMIENTO PARA TRANSFUSIÓN DE SANGRE

Su firma al pie indica que:

1. Recibió una copia del folleto "Guía de Transfusión de Sangre para Pacientes."
2. Recibió información de su doctor sobre los riesgos y beneficios de las transfusiones de sangre y de otras terapias alternativas con sus riesgos y beneficios.
3. Tuvo oportunidad de conversar con su doctor sobre este asunto, incluyendo el tema de la donación adelantada.
4. Sujeto a las instrucciones especiales que se detallan a continuación, otorga su consentimiento para cualquier transfusión de sangre que su doctor indique en relación con la operación o procedimiento que se describe en este formulario de consentimiento.

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2 The Physician Certification is not a required element of this form but is one way of providing for physician documentation of the consent process. Other options include a progress note in the patient's medical record, a note in the patient's history and physical, or documentation provided from the physician's office (e.g., an informed consent form signed by both the patient and the physician). **NOTE:** Even if the physician provides a copy of a consent form signed in the physician's office, the patient should still be asked to sign the hospital's consent form.

Instrucciones especiales: _____

_____

(Describa en este espacio cualquier instrucción específica relacionada con la transfusión de sangre del paciente; por ejemplo, donación adelantada, donación directa, etc.)

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to *(patient or patient's legal representative)* _____ in the patient's or legal representative's primary language *(identify language)* _____ _____. He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____
(interpreter)

Print name: _____
(interpreter)

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Reference: CoP Interpretive Guidelines, Tags A-0466 and A-0955