Patients and their Families

If you want help reading this form, or have questions, please ask your doctor or nurse. When we use the word treatment on this form, we mean treatment, test or operation. Please complete all appropriate sections on page 1 & 2.

Name of the patient (please print)

I agree to the treatment  Closed, possible open, reduction of distal humerus and percutaneous pinning.  

(Treatment - please print)

I agree that  

(Name of doctor or health care practitioner [HCP])

and I have talked about why this treatment is necessary and what will happen during the treatment. He/she has explained the chances of the treatment not working and the medical problems that might happen with the treatment. I also agree to other treatments that may be needed while the doctor or HCP is doing this treatment. I understand that my doctor or HCP may ask other doctors, residents, fellows or HCPs to do all or part of this treatment. I understand the information on this form and have had the opportunity to ask the doctor or HCP questions about the treatment.

Signature of patient or substitute decision maker

Date & Time

Name of substitute decision maker (if signature above)

Relationship to the patient

(A) PHYSICIAN’S, SURGEON’S OR HEALTH CARE PRACTITIONER’S STATEMENT

I certify that I have explained the nature of this treatment, its associated risks and benefits and the possible alternatives, including the likely consequences of not having the treatment, to the patient or substitute decision maker, or both.

Signature of physician, surgeon or HCP

Date & Time

Name of physician, surgeon or HCP (please print)

Summary of Risks:

Pin-tract infection requiring antibiotics and/or additional surgery

Injury to an artery requiring additional surgery

Injury to a nerve that may require additional surgery

Compartment syndrome requiring additional surgery

Residual deformity that may require additional surgery

Residual limitations of elbow range of motion that may require additional surgery

Scar
CONSENT TO TREATMENT FORM

(B) ANESTHESIOLOGIST'S STATEMENT

I certify that I have described the nature of anesthetic care the patient will receive and its associated risks to (check one) ______ the patient/_______ the substitute decision maker who has given oral consent to the provision of the described anesthetic care. I provided him or her the opportunity to ask questions.

Signature of the anesthesiologist __________________________ Date & Time __________________________

Name of the anesthesiologist (please print) __________________________

(C) BLOOD TRANSFUSION / MANUFACTURED BLOOD PRODUCTS

I have discussed the possible need for transfusion of blood products with the (check one) ______ the patient/_______ the substitute decision maker and the expected benefits, risks, side effects, alternative(s) and the likely consequences of not having a transfusion if it becomes necessary during the course of treatment. (Check one)

☐ Agreement to transfusion has been given
☐ Agreement to transfusion has NOT been given.
☐ Letter of understanding given/signed

Signature of the physician or HCP __________________________ Date & Time __________________________

Name of physician or HCP (please print) __________________________

TELEPHONE CONSENT

I have discussed the treatments and associated benefits and risks on the telephone with the (check one) ______ the patient/_______ the substitute decision maker who has given oral authorization for the treatment as per (A) (B) and/or (C).

Signature of physician or HCP __________________________ Date & Time __________________________

Name of physician or HCP (please print) __________________________

Signature of the person who witnessed conversation __________________________ Date & Time __________________________

Name of person who witnessed conversation (please print) __________________________