



(Patient Label)

GENERAL CONSENT TO ROUTINE PROCEDURES AND TREATMENT
DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

PATIENT NAME: _____ **DATE OF CONSENT:** _____

A. CONSENT:

(1) I hereby authorize Saint Joseph's Hospital of Atlanta, Inc., its agents and employees (hereinafter collectively referred to as "SJHA") and physicians on the medical staff of SJHA to provide medical treatment on an inpatient and/or outpatient basis. I acknowledge the practice of medicine is an inexact science and that no guarantees or assurances have been made to me regarding my care and treatment at SJHA or the results of such care and treatment.

(2) I acknowledge and understand that, during the course of my assessment, care and treatment, it is likely that various types of routine, diagnostic and/or treatment procedures (collectively referred to in this form as "Procedures") may be utilized, which are considered necessary or appropriate techniques for the ordinary assessment, care and treatment of my condition(s).

(3) While these types of Procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these Procedures.

(4) While it is not possible to list every risk for every Procedure utilized in modern health care, SJHA has attempted to identify the most common Procedures, their associated material risks and possible alternatives, if any, herein. I acknowledge there may be practical alternatives to the Procedure(s) described below which reasonably prudent physicians generally recognize and accept, and various health care professionals may have differing opinions regarding what constitutes a material risk and alternative procedures. I understand should I have further questions or concerns regarding these **Procedures**, my physician will provide additional information, upon request. I further acknowledge and understand my physician will provide a separate Informed Consent document which details any surgical procedure or diagnostic test which is to be performed involving general, spinal or regional anesthesia, amniocentesis, procedural sedation (such as conscious sedation), or the intravenous and/or intraductal injection of a contrast material.

(5) **Transfusion of Blood or Blood Products** (Please read and check ONE of the boxes below): During the patient's care, the patient may need to receive a transfusion of blood and/or a blood product into a vein, commonly the arm. It may consist of red blood cells, platelets, coagulation factor, plasma or some other blood product. Risks can include slight bruising, swelling or local inflammation, slight headache, fever or a mild skin reaction (such as itching or rash). A serious reaction, including death, to the transfused blood or blood product is possible although unlikely. Despite screening, the possibility exists for infections to be transmitted through donated blood, including but not limited to hepatitis, HIV, human T-cell lymphoma/leukemia virus, syphilis, and cytomegalovirus. ***I understand the administration of any transfusion(s) is a service rather than the sale of a product or good governed by the Uniform Commercial Code.***

_____ **Initial I authorize the physician to request and use blood transfusions as he/she deems necessary.**





OR

_____ Initial **I DO NOT WANT AND THEREFORE REFUSE** any transfusion(s) of blood or blood product(s). **I release Saint Joseph's Hospital of Atlanta, its affiliates, and their officers, directors, medical staff, agents and employees from any and all claims or damages arising from or relating to this refusal.** I understand that I may be asked to sign an additional form regarding this refusal.

(6) The Routine Procedures referenced in this form may include, but are not limited to the following:

(a) Injections or Intravenous Fluids which may be utilized to deliver medication or fluid into the body. Usually, medications and fluids are injected just under the skin, into the veins(s) or the muscles, but can also be given through an intravenous ("IV") line. The material risks associated with these types of routine procedures include, but are not limited to, discomfort, bruising, scarring, nerve damage, tingling, burning, paralysis or partial paralysis, loss of limb function, tissue loss, transmission of disease, hematoma, phlebitis (vein inflammation), thrombosis (formation of clotting or a blood clot), and death. Alternatives to intravenous injections or fluids may include oral, nasal, rectal or topical medications, which may be less effective, or refusal of treatment. Please see Insertion of Internal Tubes for additional information about IVs.

(b) Non-Invasive Radiographic Procedures such as X-ray, CT scan, MRI, sonogram, and/or ultrasound, which may be utilized in conjunction with diagnosis and treatment. Radiographic procedures also include radiation therapy. The material risks associated with these types of routine radiographic procedures include, but are not limited to, radiation exposure and physical injury. Apart from using an alternative type of radiographic procedure or refusal of treatment, no practical alternatives exist.

(c) Physical Tests, Therapies, Assessments and Treatments, such as vital signs, internal body examinations, range of motion checks, wound cleansing, stitches and wound dressing, physical therapies, and rehabilitation procedures, which may be utilized in conjunction with diagnosis and treatment. The material risks associated with these types of routine procedures include, but are not limited to, allergic reactions to the material(s) used, severe loss of blood, discomfort, soreness, injury to bone or muscle, nerve damage, loss of limb function, paralysis or partial paralysis, and exacerbation of the condition, including infection, scarring, and/or re-injury. Apart from using modified procedures or refusal of treatment, no practical alternatives exist.

(d) Administration of Medications which may be utilized in the care and treatment of patients, whether administered orally, rectally, topically or through eye, ear or nose. The material risks associated with administration of medications include, but are not limited to, perforation, puncture, infection, intolerance, allergic reaction, drug interaction, brain damage or death. Apart from varying the medication prescribed, method of delivery or refusal of treatment, no practical alternatives exist.

(e) Laboratory Testing which may be utilized when taking samples of blood, bodily fluids and tissue samples for laboratory analysis. The material risks associated with these types of routine procedures include, but are not limited to, those risks listed above for injections, as well as sensitivity or reaction to materials used in the collection process, such as a tourniquet, alcohol or iodine wipes, or gloves. Additionally, if the initial site does not yield an adequate collection, the use of an alternate site may be necessary. Apart from long-term observation or refusal of treatment, which could adversely affect a patient's diagnosis, care or treatment, no practical alternatives exist. Note: you/the Patient have the responsibility to 1) notify SJHA if the Patient is allergic or sensitive to any material; and 2) comply with any post-test



restrictions, such as the Patient not lifting heavy objects or performing strenuous activities, in order to reduce bruising or tenderness.

(f) Insertion of Internal Tubes such as bladder catheterizations, invasive hemodynamic monitoring, nasogastric tubes, rectal tubes, drainage tubes, chest tubes, enemas which may be utilized in conjunction with diagnosis and treatment. IVs, tubes, catheters or lines may be inserted, placed or replaced for various reasons, including as part of maintaining IV access, for patient monitoring, as part of care and treatment, for administration of medications, for pain control, and to assist in infection control. The material risks associated with these types of routine procedures include, but are not limited to, internal injuries, infection, bleeding, infection, cardiac arrhythmias, formation of thrombi and emboli, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection and blood pressure monitoring devices or refusal of treatment, no practical alternatives exist.

(g) Monitoring and Daily Care such as physical exams, application of monitors and other devices, baths and other general hygiene care, and transportation of the patient to/from various hospital areas or departments. The material risks associated with these types of routine procedures include, but are not limited to, discomfort, falls, injury, and loss of personal privacy. Apart from using modified treatments or procedures or refusal of same, no practical alternatives may exist.

(7) In addition to the Procedures listed above, I understand there are **other treatments and procedures** which are commonly performed on hospital patients and outpatients (also collectively referred to as "Procedures"). The risks of these Procedures can include discomfort, pain, bleeding or severe loss of blood, bruising, soreness, physical injury, exacerbation of condition, infection, allergic reactions, adverse reactions, loss of personal privacy, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest or death. Apart from using modified Procedures or refusal of same, no practical alternatives may exist.

(8) I consent to and authorize the persons participating in and responsible for my care to utilize and perform Procedures such as those set forth herein, as they may deem reasonably necessary, appropriate or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also specifically extend to the treatment of all conditions which may arise during the course of such Procedure(s) including those conditions which may be unknown or unforeseen at the time this consent is obtained. I agree to provide accurate and complete information regarding the Patient's medical history and condition(s), and I understand SJHA will rely on such information in determining whether to perform the Procedure.

(9) I acknowledge, understand and confirm by signing this form that I have been informed in general terms of the following and have received sufficient information regarding the Procedures:

- (a)** The nature and purpose;
- (b)** The material risks (see above);
- (c)** The practical, reasonable alternatives;
- (d)** The likelihood of achieving goals and success;
- (e)** The prognosis if the Procedure(s) is rejected;
- (f)** The relevant risks, benefits, and side effects related to the alternatives, including the possible results of not receiving the Procedures;
- (g)** Potential problems that might occur during recuperation; and
- (h)** When indicated, any limitations on the confidentiality of information learned from or about the Patient.



B. ACKNOWLEDGEMENT that physicians at SJHA and their assistants are not employees of Saint Joseph's Hospital of Atlanta, Inc. (or Saint Joseph's Health System, Inc. or any of its affiliated entities):

I fully understand some or all of the health care professionals performing services at SJHA are independent contractors and are not SJHA agents or employees. Independent contractors are responsible for their own actions and SJHA shall not be liable for the acts or omissions of any such independent contractor.

C. USE AND DISCLOSURE OF INFORMATION:

I acknowledge that I have been provided with SJHA's Notice of Privacy Practices, which discusses use and disclosure of protected health information which may be made by SJHA, as well as patient rights and other information. I understand a copy of this Notice is also available upon request.

I also authorize SJHA, its affiliates, its agents and employees to utilize or disclose my health information, data and records maintained by SJHA for purposes of conducting research, compiling registry data, education, management audits, utilization review/peer review activities, program evaluations or other audit and evaluation activities. I recognize such information may be obtained in connection with this or previous hospitalization(s).

As part of registration and admission, I understand I will be asked to provide personal information, such as the Patient's date of birth and social security number. I understand SJHA will ask me in person to provide such information, and that I should not give such information over the phone to anyone.

I understand and acknowledge that SJHA has an Electronic Intensive Care Unit ("eICU") in which advanced technology, such as telemedicine, computer monitors, high resolution cameras and computer software, provides an extra layer of monitoring for critical care patients who are in the Intensive Care Unit ("ICU"). I understand such monitoring takes place in the ICU at SJHA, and the resulting information is used by SJHA for purposes of patient care and treatment, staff training and education, eICU program development, and as otherwise permitted under HIPAA. I understand the monitoring images are not printed out or retained and that additional information about the eICU can be found in patient rooms and in SJHA's admission booklet.

D. CONSENT FOR OBSERVATION OR ASSISTANCE:

I consent that fellows, residents, and interns may observe or assist in the Procedures performed upon me at SJHA, for purposes of research, training and education. I consent that students and certain medical company representatives may also observe the Procedures performed upon me at SJHA for purposes of research, training and education.

E. RELEASE OF LIABILITY FOR PERSONAL VALUABLES:

I understand valuables should not remain at SJHA and that SJHA has a safe and is willing to hold any valuables. I hereby release SJHA, its affiliates, employees and agents from liability for loss or damage to any valuables or other such personal property. When not in use, it is the responsibility of the Patient and/or the Patient's family to assure dentures, eyeglasses, and hearing aids are placed in protective containers since SJHA cannot be responsible for breakage or loss of such articles.

F. CONSENT FOR DISPOSAL OF HUMAN TISSUE:

I agree any tissues, specimens, body parts, products of conception, and fetal remains may be examined, autopsied and disposed of by SJHA.



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G. GENERAL CONSENT TO BE PHOTOGRAPHED, RECORDED OR FILMED:

I consent to be photographed, recorded or filmed, including the use of digital camera equipment with no enhancements or changes made to the picture, for SJHA's internal purposes, such as related to security, identification, performance improvement, education, training, treatment and diagnosis.

H. RECEIPT OF ADMISSIONS AND GENERAL INFORMATION BOOKLET:

I acknowledge I have received SJHA's Admissions and General Information Booklet. I understand I should read this booklet and that it contains important information about several topics, including patient rights and responsibilities.

I. SIGNATURE BY PATIENT:

(*Patient must mark out and initial any Procedure and/or section of this form for which consent is not granted.)

I UNDERSTAND THAT THIS CONSENT AND RELEASE SHOULD BE READ BEFORE SIGNING, AND I HAVE READ AND UNDERSTAND THIS DOCUMENT.

Signature of Patient Giving Consent

Date

Time

Print Name

Signature of Witness (certifying present when form signed; can be adult family member, responsible adult who is present, or SJHA agent/employee present during signing)

Date

Time

J. SIGNATURE BY PERSON OTHER THAN PATIENT:

I UNDERSTAND THAT THIS CONSENT AND RELEASE SHOULD BE READ BEFORE SIGNING, AND I HAVE READ AND UNDERSTAND THIS DOCUMENT.

Signature of Person Giving Consent

Date

Time

Print Name and Relationship to Patient

Signature of Witness (certifying present when form signed; can be adult family member, responsible adult who is present, or SJHA agent/employee present during signing)

Date

Time