Informed Consent

Client ID#_____ Client Full Name_____
DOB_____ Clinician Full Name_____
Facility_____

1. DIAGNOSIS:_____
   _____
   _____
2. TREATMENT:_____
   _____
   _____
   a. BENEFITS AND RESULTS:
      _____
      _____
   b. COMMON AND IMPORTANT RISKS:
      _____
      _____
   c. ALTERNATIVES:
      _____
      _____
   d. COMPLICATIONS:
      _____
      _____
   e. RELATIVE CHANCES OF SUCCESS:
      _____
      _____
   f. EXPECTATIONS:
      _____
      _____
3. PATIENT CONSENT (Line through any parts which are not appropriate)
   a. I hereby give my consent and authorize (Provider name)_____ of the (facility)_____, and such assistants as may be approved by said provider, to perform the above named treatment. All my questions, if any, have been answered to my satisfaction. I acknowledge that no guarantee has been made to me as to the results that may be obtained.
   b. I consent to the performance of the above named treatment and to such additional treatments as are found to be necessary or desirable in the best judgement of the clinical staff during the planned treatment.
   c. I consent to the admittance of observers, in accordance with ordinary practices of the facility named above.
   d. I have been provided with my treatment plan.

i. I understand that my compliance with the plan is an important component of the success of my treatment
ii. I understand I can withdrawal from treatment.
iii. I understand treatment may include outside clinicians.

4. PATIENT: I understand the nature of my condition, the proposed treatment, its risks and the alternative, and the expected results, and I hereby request the treatment be performed. I DO/DO NOT wish the services of a translator.

_____ _____ _____
Signature of Witness Signature of Patient Date Time

5. IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING: Patient is a minor (under 14) or is unable to sign because: I,_____, sponsor / guardian of, understand the nature of the patient's condition, the proposed treatment, its risks and the alternatives, and the expected results as described above, and I hereby request the treatment be performed. I DO/DO NOT wish the services of a translator.

_____ _____ _____
Signature of Witness Signature of Parent or Legal Guardian Date Time

6. COUNSELING PROVIDER: I have counseled this patient as to the nature of his/her condition, the proposed treatment, the risks, alternatives, and expected results.

_____ _____ _____
Signature of Provider Securing Consent Date PATIENT IDENTIFICATION

7. TRANSLATOR I_____, have translated the information and advice presented orally to the person giving the consent. I have also read him/her the authorization form in the language _____and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

_____ _____
Translator's Signature Date