BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent

This information is given to you so that you can make an informed decision about your child having
Image Guided Radiology Procedure:_____

Body Location: _____

Reason and Purpose of the Procedure

A radiology doctor will do this procedure on your child. The doctor may use ultrasound, computer tomography (CT), or X-ray to get images. These images will help the doctor guide precise placement of needles or catheters. A catheter is a small hollow tube. The doctor will also use an x-ray during the procedure. The x-ray will help your doctor get images. The images will also be used to document results.

Your child will be sedated for the procedure and probably will not remember it. If general anesthesia is needed, that will be discussed with you. A numbing medication will be injected at the procedure site.

Benefits of this procedure

Your child might receive the following benefits. Your doctor cannot promise your child will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- _____
- _____
- _____
- _____

Risks of Procedures

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General Risks of Procedures

- **Bleeding.** In rare cases this could require a blood transfusion or an emergency procedure to stop bleeding.
- **Infection.** Can occur in the skin, soft tissue under the skin, or internally. Your child may need antibiotics.
- **Injury to body structures or organs at or near the procedure site**. This could require additional treatment.

Potential Radiation Risks to your child include

- **Any exposure to radiation may cause a slightly higher risk for cancer** later in life. This risk is low.
- **Skin rashes**. Very rarely, skin rashes may lead to tissue breakdown and possibly severe ulcers.
- **Hair loss**. The chance of this happening depends on each individual. This does not happen to everyone. This can be temporary or permanent.
- **You will be advised if we used much higher amounts of radiation during the procedure.**
- **If you see changes with your child's skin you should report them to your doctor.**

Risks specific to your child

- _____
- _____
- _____
- _____

Risks associated with Obesity

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Alternative Treatments

Other choices:

- Do nothing. You can decide your child will not have the procedure done.
- _____

If you choose not to have this treatment

- Your child's medical condition may not be diagnosed or treated.
- Your child might need surgery that could be avoided if he or she had the procedure.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Small tissue samples might be removed. They could be kept for research or teaching. I agree the hospital may discard the tissues in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Radiology images will be obtained. They will be part of my medical record. These may be published for teaching purposes. My identity will be protected

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By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with my child's t doctor. My questions have been answered.
- I want my child to have this procedure: **Radiology imaging guided** _____
  _____
- I understand that my doctor may ask a partner to do the surgery/procedure.
- I understand that other doctors, including medical residents or other staff, may help with procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Parent Signature_____Date:_____Time:_____
Relationship: ☐Parent ☐Closest relative (relationship)_____ ☐Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter:_____Date:_____ Time:_____
Interpreter (if applicable)

For Provider Use ONLY:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and parent has agreed to procedure.

Parent shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____

OR
____ Parent elects not to proceed: _____ Date:_____ Time:_____
(parent signature)
Validated/Witness:_____ Date:_____Time:_____