BRONSON

Affix Patient Label

Consent for Minor Procedure in Practice/Clinic Setting

Name: _____ Date of Birth: _____

Attending/Supervising Physician: _____

Resident Physician (if applicable): _____ Type of Supervision: ☐ Direct ☐ Indirect

Procedure: _____

_____

Benefits of this Procedure:

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

- _____
- _____
- _____

General 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.

- Redness/skin discoloration at the procedure site.
- Bleeding. You may have a small amount of bleeding from broken blood vessels in the skin or muscle.
- Infection. Whenever there is a break in the skin, like when a needle is used to give medications, there is chance of infection. Your doctor will clean the skin to reduce the risk of infection.
- Soreness at the procedure or injection site. You may notice pain, warmth, and slight swelling at the site.These symptoms generally do not last long. You may want to use an ice pack to help soreness.

Risks of this Procedure:

No procedure is completely risk free. Some risks are well known. There may be risks that your doctor can't expect.

- _____
- _____
- _____

Risks Associated with Smoking:

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

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.

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.

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Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to 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 the doctor. My questions have been answered.
- I want to have this procedure: _____

  _____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the procedure. The tasks will be based on their skill level. My doctor will supervise them.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Closest relative (relationship) _____ ☐ Guardian/POA Healthcare

Witness Signature: _____ Date: _____ Time: _____

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

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: _____