BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Pediatric Image-Guided Radiology Procedure

This information is given to you so that you can make an informed decision about your child having an **image-guided radiology procedure.**

Reason and Purpose of this 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 may receive sedation or general anesthesia. 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. Their doctor cannot promise they 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 child's doctor cannot expect.

- **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.

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.

Risks Specific to Your Child:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to have the procedure.
- _____

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.

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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.

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 salespeople, and other staff may be present during the procedure. My child's doctor will supervise them.

Pictures and videos may be taken during the procedure. These may be added to my child's medical record. These may be published for teaching purposes. My child's 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 doctor. My questions have been answered.
- I want my child to have this procedure: **Image-Guided Radiology Procedure:** _____
  Body Location: _____
- I understand that my child's 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.

Provider: This patient may require a type and screen or type and cross prior to procedure. If so, please obtain consent for blood/products.

Patient Signature: _____ Date: _____ Time: _____

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

Reason patient is unable to sign: _____

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: _____

Telephone Consent ONLY: *(One witness signature MUST be from a registered nurse (RN) or provider)*

1st Witness Signature: _____ 2nd Witness Signature: _____ 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: _____

Teach Back:

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: _____