JOHNS HOPKINS
MEDICINE

15-144020

☐ Johns Hopkins Hospital ☐ Johns Hopkins Community Physicians
☐ Johns Hopkins Bayview ☐ Other: _____

for addressograph plate/label

Consent for Performance of Procedures/Treatment/ Operations or Other Procedures Page 1 of 2

Date:_____ PATIENT NAME (Print) _____

1) I hereby give my consent and authorize _____ and the Johns Hopkins treatment team,
First Name Last Name
to perform the following operation(s) treatment(s) or procedures(s) _____

(Identify operative site and side, use no abbreviations, and explain in non-medical terms)

2) The indications, benefits and probability of success of the operation(s), treatment(s) or procedure(s) have been explained to me in a manner that I understand. These include:

3) The major risks and complications of the operation, treatment or procedure have been explained to me in a manner that I understand. These may include such items as failure to obtain the desired result, discomfort, injury, need for additional treatment(s) and death. Additional risks include: _____

(Include common, infrequent and local anesthesia risks)

4) I understand that the reasonable alternatives to the proposed operation(s), treatment(s) or procedure(s), including the major risks, benefits, and side effects of those alternatives are:

Alternatives:	**Major Risks, Benefits, and Side Effects of Each Alternative:**

5) During the procedure, the provider may become aware of conditions which were not apparent before the start of the procedure. I consent to additional or different operations or procedures the provider considers necessary or appropriate to diagnose, treat, or cure such conditions.

6) Johns Hopkins may dispose of any tissue or parts which are removed during the procedure. Johns Hopkins may retain, preserve and use these tissues or parts for internal educational and quality improvement purposes without my permission, even if these tissues or parts identify me. However, Johns Hopkins may only use or disclose tissues or parts that identify me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If the tissues or parts do not identify me, Johns Hopkins may use them for scientific (research) purposes without my permission or action by a review board.

JOHNS HOPKINS
MEDICINE

15-144020

☐ Johns Hopkins Hospital ☐ Johns Hopkins Community Physicians
☐ Johns Hopkins Bayview ☐ Other: _____

for addressograph plate/label

Consent for Performance of Procedures/Treatment/ Operations or Other Procedures Page 1 of 2

Date:_____ PATIENT NAME (Print) _____

1) I hereby give my consent and authorize _____ and the Johns Hopkins treatment team,
First Name Last Name
to perform the following operation(s) treatment(s) or procedures(s) _____

(Identify operative site and side, use no abbreviations, and explain in non-medical terms)

2) The indications, benefits and probability of success of the operation(s), treatment(s) or procedure(s) have been explained to me in a manner that I understand. These include:

3) The major risks and complications of the operation, treatment or procedure have been explained to me in a manner that I understand. These may include such items as failure to obtain the desired result, discomfort, injury, need for additional treatment(s) and death. Additional risks include: _____

(Include common, infrequent and local anesthesia risks)

4) I understand that the reasonable alternatives to the proposed operation(s), treatment(s) or procedure(s), including the major risks, benefits, and side effects of those alternatives are:

Alternatives:	**Major Risks, Benefits, and Side Effects of Each Alternative:**

5) During the procedure, the provider may become aware of conditions which were not apparent before the start of the procedure. I consent to additional or different operations or procedures the provider considers necessary or appropriate to diagnose, treat, or cure such conditions.

6) Johns Hopkins may dispose of any tissue or parts which are removed during the procedure. Johns Hopkins may retain, preserve and use these tissues or parts for internal educational and quality improvement purposes without my permission, even if these tissues or parts identify me. However, Johns Hopkins may only use or disclose tissues or parts that identify me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If the tissues or parts do not identify me, Johns Hopkins may use them for scientific (research) purposes without my permission or action by a review board.

PATIENT'S COPY

TURN OVER TO COMPLETE PAGE 2

JOHNS HOPKINS
MEDICINE

15-144020

☐ Johns Hopkins Hospital ☐ Johns Hopkins Community Physicians
☐ Johns Hopkins Bayview ☐ Other: _____

for addressograph plate/label

Consent for Performance of Procedures/Treatment/ Operations or Other Procedures Page 2 of 2

7) By signing below I agree:

- That a provider has explained and answered all of my questions related to:_____

_____
(Operation/treatment/procedure as listed on page #1)

- If I have further questions, I have the right to have those questions answered.
- That no guarantees were made concerning the outcome, as the practice of medicine and surgery is not an exact science.
- To have the operation(s), treatment(s) or procedure(s).
- That I have identified to a provider any restrictions on the sharing of information learned from the operation(s) or procedure(s).
- I have not given up my right to refuse treatment at any time.
- That I am entitled to a signed copy of this consent form.

For the following statement, if the patient does not agree, cross it out with a single line. The patient and provider shall initial, date and time the cross-out:

- To allow observers or technical advisors to be present during the operation(s) or procedure(s).

Patient Signature		Date	Time
Signature (full name) of Provider Obtaining Consent	Title	Date	Time

First Name: _____ Last Name:_____ ID No. ☐☐☐☐☐
Provider's Name (PRINT)

Witness Signature		Date	Time

☐ In-person ☐ By phone/computer

Interpreter's Printed Name	Interpreter's Signature (if In-person)	Date	Time

PATIENT IS UNABLE TO CONSENT BECAUSE: ☐ Patient is a minor ☐ Patient lacks capacity
☐ Other (describe)_____

Signature of Authorized Representative	Relationship	Date	Time
Witness Signature		Date	Time

DO NOT COMPLETE THE SECTION BELOW UNTIL THE FINAL TIME-OUT IS CONDUCTED

TIME-OUT VERIFICATION

This documents that a final verification (time-out) was performed prior to starting the procedure. Documentation of time out may be completed elsewhere in the patient's medical record (e.g., procedure/progress note, procedure flowsheet, checklist, ORMIS). I verify that the treatment team (for OR, minimum of provider, anesthesiologist/CRNA, circulating RN) participated in the time out using active communication and that we verified the following:

- Correct patient identity
- Agreement on procedure to be done (as stated on the informed consent)
- Correct side and site procedure

SIGNATURE AND TITLE OF PERSON VERIFYING TIME-OUT WAS PERFORMED	PRINTED FIRST AND LAST NAME
DOCUMENT DATE AND TIME THAT THE TIME-OUT WAS PERFORMED:	DATE _____ TIME _____ A.M./P.M.

PATIENT'S COPY

JOHNS HOPKINS
MEDICINE

15-144020

☐ Johns Hopkins Hospital ☐ Johns Hopkins Community Physicians
☐ Johns Hopkins Bayview ☐ Other: _____

for addressograph plate/label

Consent for Performance of Procedures/Treatment/ Operations or Other Procedures Page 2 of 2

7) By signing below I agree:

- That a provider has explained and answered all of my questions related to:_____

_____
(Operation/treatment/procedure as listed on page #1)

- If I have further questions, I have the right to have those questions answered.
- That no guarantees were made concerning the outcome, as the practice of medicine and surgery is not an exact science.
- To have the operation(s), treatment(s) or procedure(s).
- That I have identified to a provider any restrictions on the sharing of information learned from the operation(s) or procedure(s).
- I have not given up my right to refuse treatment at any time.
- That I am entitled to a signed copy of this consent form.

For the following statement, if the patient does not agree, cross it out with a single line. The patient and provider shall initial, date and time the cross-out:

- To allow observers or technical advisors to be present during the operation(s) or procedure(s).

_____ _____ _____
Patient Signature Date Time

_____ _____ _____ _____
Signature (full name) of Provider Obtaining Consent Title Date Time

First Name: _____ Last Name:_____ ID No. ☐☐☐☐☐
Provider's Name (PRINT)

_____ _____ _____
Witness Signature Date Time

☐ In-person ☐ By phone/computer _____ _____ _____ _____
Interpreter's Printed Name Interpreter's Signature (if In-person) Date Time

PATIENT IS UNABLE TO CONSENT BECAUSE: ☐ Patient is a minor ☐ Patient lacks capacity
☐ Other (describe)_____

_____ _____ _____ _____
Signature of Authorized Representative Relationship Date Time

_____ _____ _____
Witness Signature Date Time

DO NOT COMPLETE THE SECTION BELOW UNTIL THE FINAL TIME-OUT IS CONDUCTED

TIME-OUT VERIFICATION

This documents that a final verification (time-out) was performed prior to starting the procedure. Documentation of time out may be completed elsewhere in the patient's medical record (e.g., procedure/progress note, procedure flowsheet, checklist, ORMIS). I verify that the treatment team (for OR, minimum of provider, anesthesiologist/CRNA, circulating RN) participated in the time out using active communication and that we verified the following:

- Correct patient identity
- Agreement on procedure to be done (as stated on the informed consent)
- Correct side and site procedure

_____ _____
SIGNATURE AND TITLE OF PERSON VERIFYING TIME-OUT WAS PERFORMED **PRINTED FIRST AND LAST NAME**

DOCUMENT DATE AND TIME THAT THE TIME-OUT WAS PERFORMED: **DATE**_____ **TIME**_____ **A.M./P.M.**