Proposed Procedure/Treatment(s): _____

I, the undersigned, a patient at Broadlawns Medical Center have discussed with my provider(s) and have been advised that the procedure(s) listed above is/are medically necessary and/or therapeutically necessary in the diagnosis and treatment of my condition. Therefore, I authorize and direct DOUGLAS A. WALDMAN, MD (Name of provider) and assistants/associates of his or her choice to perform the procedure(s) listed. I also consent to the administration of local anesthetics as are necessary, with the exception of _ NONE . Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practice.

I understand that, at times for clinical or educational purposes, it may be necessary to photograph or videotape this procedure. I hereby consent to be photographed and/or videotaped and understand the photographs and/or videotape may be retained by BMC. ☐ No ☐ Yes If YES, complete form S/MR 1122, Consent for Photography, Videotaping and Other Imaging.

The nature and purpose of the procedure, benefits, risks, complications, possible treatment alternatives, and problems related to recuperation, likelihood of success, and anticipated results if the treatment or procedure is not performed have been explained to me by DOUGLAS A. WALDMAN, MD. I acknowledge that this disclosure has been made and that all questions asked with regard to the procedure have been answered in a satisfactory manner.

I acknowledge that I have read and agree to the foregoing procedure/treatment and that it has been satisfactorily explained. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I hereby consent to the above procedure/treatment(s) and fully authorize them to be performed.

Signature of Patient or Surrogate Decision Maker	Date	Time
Signature of Witness	Relationship to Patient	

ATTESTATION OF PHYSICIAN

I attest that informed consent has been provided including the risks, benefits, potential complications and alternatives to the procedure. I have asked the patient receiving the proposed procedures/treatment to re-state in their own words what type of procedure/treatment they are receiving and I attest that he/she understands.

X Signature of Physician/Provider	Date	Time

TIME OUT documentation on reverse side

STATEMENT OF INTERPRETER

I have translated the information that was presented orally to the patient (or his/her legal representative) by the person obtaining this consent. I have also translated this consent form to the patient/legal representative in the _____ language. I am qualified to provide this translation, and to the best of my belief, I have accurately translated this information to the patient or his/her legal representative, and he/she understood the information and ☐ DID ☐ DID NOT consent to the procedure.

PRINT Name of Interpreter

Signature of Interpreter	Date	Time

broadlawns MEDICAL CENTER
Outpatient Clinics
Consent/Time Out

S/MR-1140
64120 (10/12dip)

TIME OUT

Performed prior to the procedure	CRITERIA PATIENT VERIFICATION (PRE-PROCEDURE)
☐	• Verification of Patient performed (Name/MRN/DOB) by staff member. • Allergies Verified. (Including Latex). • Patient's responses match ID band, consents, X-rays (if applicable) and all other relevant data. • Confirm completion of all items on preoperative checklist, as appropriate. • As appropriate to the procedure, pre-op antibiotics given within 60 minutes.
	SITE MARK (PRE-PROCEDURE)
☐	• Patient states procedure, side and site to be performed and points to the site. • All relevant data in the medical record is consistent with patient response. • Site is marked by physician with permanent marker, as appropriate.
	TIME OUT **Performed immediately prior to the invasive procedure or making the incision.**
☐	As appropriate to the patient and the procedure being performed, the time out consist of: • Correct patient identity • Correct side and site (Confirm site marking) • Procedure to be done X _____ Signature _____ _____ Date Time
	Discrepancy Noted
☐	• Physician notified Date: _____ Time: _____ • Verification discrepancy resolved and communicated with all involved staff. • Documentation of discrepancy and resolution completed.