

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH UNIVERSITY MEDICAL CENTER
GENERAL INFORMED CONSENT
MINOR PROCEDURES
SURROGATE

Consent-E
General Consent - Minor Procedures Surrogate



IDN13150115

1. I hereby authorize Dr. _____ and/or such assistants and associates as may be selected by him/her to perform the following procedure(s)/treatment(s) upon the patient

_____ (who lacks decisional capacity to make medical decisions on his/her own behalf.)

Procedure(s)/Treatment(s) _____

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. The attending physician has explained to me the following:

- A. The nature of the recommended procedure(s)/treatment(s).
- B. The purpose of and need for the recommended procedure(s)/treatment(s).
- C. The possible risks and complications of the recommended procedure(s)/treatment(s).
- D. The alternatives, if any, to the recommended procedure(s)/treatment(s).

I understand the explanation provided and give this consent voluntarily on behalf of the above-noted patient.

3. I understand that some physicians who may be treating the patient are not employees or agents of Rush University Medical Center but are independent medical practitioners who are solely and exclusively responsible for the exercise of their medical judgment.

4. This direction is given by me as the patient's surrogate decision maker in accordance with the Illinois Health Care Surrogate Act and after consultation with the above-noted attending physician.

5. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s).

6. For the purpose of advancing medical education, I consent to the admittance of observers to the room in which the procedure(s)/treatment(s) is performed.

7. I acknowledge that I have read this document and the information sheet entitled (if no information sheet is provided, leave blank) _____ and that I fully understand them.

Date: _____

Signature of Surrogate Decision Maker

Time: _____ A.M. / P.M.

WITNESS:

Relationship

Signature of Witness

(OVER)

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PHYSICIAN AFFIRMATION

My signature below affirms that prior to the time of the procedure, I have explained to the patient's surrogate the nature of the recommended procedure, the need for the recommended procedure, the risks and benefits involved in the proposed treatment and any reasonable alternative to the proposed treatment. I have also explained the risks and benefits involved in refusal of the proposed treatment and have answered the patient's surrogate's questions.

Date: _____

Signature of Physician

TELEPHONE CONSENT

Verbal authorization for the procedure(s)/treatment(s) in paragraph 1 above was obtained from the consenting party named below who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information in paragraph 2 above.

Date: _____

Name of Consenting Party

Time: _____ A.M. / P.M.

WITNESS:

Signature of Witness

Relationship to Patient

INSTRUCTIONS: This consent form should be signed by a surrogate decision maker who is an adult with decisional capacity, available upon reasonable inquiry, willing to make decisions regarding medical treatment on behalf of a patient who lacks decisional capacity and who is one of the following individuals: 1) the patient's guardian of the person; 2) the patient's spouse; 3) any adult son or daughter of the patient; 4) either parent of the patient; 5) any adult brother or sister of the patient; 6) any adult grandchild of the patient; 7) a close friend of the patient; or 8) the patient's guardian of the estate.