

RUSH UNIVERSITY MEDICAL CENTER  
**GENERAL INFORMED CONSENT**  
**(SHORT FORM)**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

Consent-E  
General Informed Consent



IDN13150039

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

Procedure(s)/Treatment(s) \_\_\_\_\_

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. I have been informed of the following:

- The nature of the proposed care, treatment, services, medications, interventions, or procedures
- Potential benefits, risks, or side effects of the proposed care, treatment, services, medications, interventions, or procedures, the likelihood of achieving his/her goals, and the potential problems that might occur during recuperation
- The likelihood of achieving care, treatment, and service goals
- Reasonable alternatives to the proposed care, treatment, and service
- If warranted, the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services
- When indicated, any limitations on the confidentiality of information learned from or about the patient

I understand the information provided and give this consent voluntarily.

3. I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and drugs: (If none, leave blank) \_\_\_\_\_

4. I understand that some physicians who may be treating me or the above-noted 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.

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. Such observers may be health care professionals, students, clinical device specialists or others as may be identified by my physician/health care provider.

7. I have read the information sheet entitled (if no information sheet is provided, leave blank). \_\_\_\_\_

8. I acknowledge that I have read and fully understand this document and that if I have questions I have had the opportunity to have them answered by the physician/health care provider.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Consenting Party*

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Print Name*

**WITNESS TO SIGNATURE OF CONSENTING PARTY:**

**IF CONSENTING PARTY IS OTHER THAN PATIENT:**

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Signature of Consenting Party*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Relationship*

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**INFORMED CONSENT AFFIRMATION**

My signature below affirms that prior to the time of the procedure, I explained to the patient and/or his/her guardian the nature of the proposed treatment; potential benefits, risks or side effects; the likelihood of achieving treatment goals; if warranted, the relevant risks, benefits, and side effects related to alternatives; and, when indicated, any limitations on the confidentiality of information learned from or about the patient.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Licensed Health Care Provider*

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Print Name*

**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: \_\_\_\_\_

\_\_\_\_\_  
*Print Name of Consenting Party*

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Relationship to Patient*

**WITNESS AND RECIPIENT OF CONSENT:**

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Print Name*

**INSTRUCTIONS:** This consent form should be signed by the patient if an adult (18 years and older), by a parent or court-appointed guardian if the patient is a minor or by a court-appointed guardian if the patient has been declared legally incompetent.