IHS-515 (11/94)

AUTHORIZATION FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS OR OTHER PROCEDURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service

1. DIAGNOSIS *(include lay terms as necessary)*

Central Venous Line

☐ Access to vein ☐ Deliver medications to larger vein

2. OPERATION OR PROCEDURE *(include explanation in lay terms)*

Clean skin, then numb skin. Insert needle deep into large vein in chest or leg. Using a wire, then insert catheter into vein. Sew catheter into place

Common and important risks associated with the proposed operation or procedure include:

Collapsed lung, Infection, blood clot in vein, and bleeding.

Alternatives to the proposed operation or procedure include:

Not do procedure.

3. PATIENT CONSENT *(Line through any parts which are not appropriate)*

A. I hereby give my consent and authorize (*Provider name*) _____ of the _____ facility, and such assistants as may be approved by said provider, to perform the above named operation or procedure. All my questions, if any, have been answered to my satisfaction. I acknowledge that no guarantee has been made to me as to the results that may be obtained.

B. I consent to the performance of the above named operation or procedure and to such additional operations or procedures as are found to be necessary or desirable in the best judgment of the medical staff during the planned operation or procedure.

C. I consent to the administration of such anesthesia as may be considered necessary or advisable in the judgment of the medical staff. Exceptions to surgery or anesthesia, if any, are: *(If none, so state)* _____

D. I consent to the disposal by authorities of the facility named above of any body tissues or parts which it may be necessary to remove. I authorize the facility to retain, preserve, and use for scientific or teaching purposes any tissue or specimens taken from my body.

E. I consent to the admittance of observers, in accordance with ordinary practices of the facility named above. I understand that photographs, movies, and video tapes may be taken of this operation or procedure, and that they may be viewed by personnel undergoing training at this or other facilities. I consent to the viewing of such movies, video tapes, and photographs for scientific purposes, provided my identity is not revealed by the pictures or written information accompanying them.

4. PATIENT: I understand the nature of my condition, the proposed operation or procedure, its risks and the alternatives, and the expected results, and I hereby request the operation or procedure be performed. I DO ☐ DO NOT ☐ wish the services of a translator.

Signature of Witness	Signature of Patient	Date	Time	☐ a.m. ☐ p.m.

5. IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING: Patient is a minor (_____ years of age) or is unable to sign because: _____

I, _____, sponsor/guardian of _____, understand the nature of the patient's condition, the proposed operation or procedure, its risks and the alternatives, and the expected results as described above, and I hereby request the operation or procedure be performed. I DO ☐ DO NOT ☐ wish the services of a translator.

Signature of Witness	Signature of Parent or Legal Guardian	Date	Time	☐ a.m. ☐ p.m.

6. COUNSELING PROVIDER: I have counseled this patient as to the nature of his/her condition, the proposed operation or procedure, the risks, alternatives, and expected results.

Signature of Provider Securing Consent _____ Date _____

PATIENT IDENTIFICATION

7. TRANSLATOR

I, _____ have translated the information and advice presented orally to the person giving this consent. I have also read him/her the authorization form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

Translator's Signature _____ Date _____

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*U.S. Government Printing Office: 1996 - 404-893/33104