Atlantic Health System

December 5, 2019

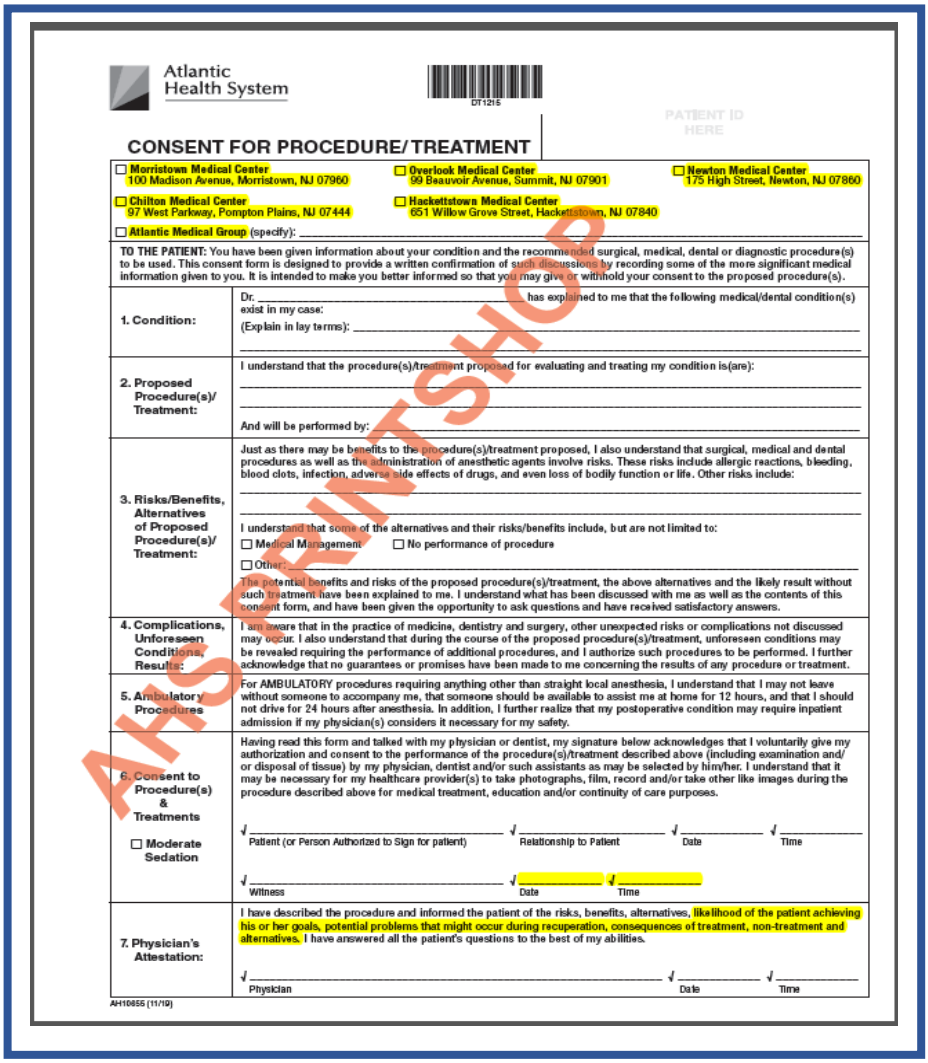
Revised "Informed Consent" Form FLASH

ATTENTION: The revised "Informed Consent" forms are now available to order from the PRINTSHOP Storefront.

Changes are highlighted on the sample form below.

Appropriate site must be checked off when completing the form.

Please discard ALL old versions of the English and Spanish version.



Atlantic Health System

DT1215

PATIENT ID HERE

CONSENT FOR PROCEDURE/TREATMENT

☐ Morristown Medical Center, 100 Madison Avenue, Morristown, NJ 07960
☐ Overlook Medical Center, 99 Beauvoir Avenue, Summit, NJ 07901
☐ Newton Medical Center, 175 High Street, Newton, NJ 07860
☐ Chilton Medical Center, 97 West Parkway, Pompton Plains, NJ 07444
☐ Hackettstown Medical Center, 651 Willow Grove Street, Hackettstown, NJ 07840
☐ Atlantic Medical Group (specify): _____

TO THE PATIENT: You have been given information about your condition and the recommended surgical, medical, dental or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. Condition: Dr. _____ has explained to me that the following medical/dental condition(s) exist in my case:
(Explain in lay terms): _____

2. Proposed Procedure(s)/ Treatment: I understand that the procedure(s)/treatment proposed for evaluating and treating my condition is(are):
_____
And will be performed by: _____

3. Risks/Benefits, Alternatives of Proposed Procedure(s)/ Treatment: Just as there may be benefits to the procedure(s)/treatment proposed, I also understand that surgical, medical and dental procedures as well as the administration of anesthetic agents involve risks. These risks include allergic reactions, bleeding, blood clots, infection, adverse side effects of drugs, and even loss of bodily function or life. Other risks include:
_____
I understand that some of the alternatives and their risks/benefits include, but are not limited to:
☐ Medical Management ☐ No performance of procedure
☐ Other: _____
The potential benefits and risks of the proposed procedure(s)/treatment, the above alternatives and the likely result without such treatment have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

4. Complications, Unforeseen Conditions, Results: I am aware that in the practice of medicine, dentistry and surgery, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s)/treatment, unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

5. Ambulatory Procedures: For AMBULATORY procedures requiring anything other than straight local anesthesia, I understand that I may not leave without someone to accompany me, that someone should be available to assist me at home for 12 hours, and that I should not drive for 24 hours after anesthesia. In addition, I further realize that my postoperative condition may require inpatient admission if my physician(s) considers it necessary for my safety.

6. Consent to Procedure(s) & Treatments ☐ Moderate Sedation: Having read this form and talked with my physician or dentist, my signature below acknowledges that I voluntarily give my authorization and consent to the performance of the procedure(s)/treatment described above (including examination and/or disposal of tissue) by my physician, dentist and/or such assistants as may be selected by him/her. I understand that it may be necessary for my healthcare provider(s) to take photographs, film, record and/or take other like images during the procedure described above for medical treatment, education and/or continuity of care purposes.

✓ _____ Patient (or Person Authorized to Sign for patient) ✓ _____ Relationship to Patient ✓ _____ Date ✓ _____ Time

✓ _____ Witness ✓ _____ Date ✓ _____ Time

7. Physician's Attestation: I have described the procedure and informed the patient of the risks, benefits, alternatives, likelihood of the patient achieving his or her goals, potential problems that might occur during recuperation, consequences of treatment, non-treatment and alternatives. I have answered all the patient's questions to the best of my abilities.

✓ _____ Physician ✓ _____ Date ✓ _____ Time

AH10655 (11/19)

Order #

English- AH10655

Spanish- AH10859