GWINNETT MEDICAL GROUP

CONSENT TO GENERAL CARE/ROUTINE PROCEDURES AND TREATMENT

Important: Do not sign this form without reading and understanding its contents.

Patient Name (print)_____ Date of Birth _____

CONSENT AND TREATMENT AUTHORIZATION: I hereby consent to the provision of general care by my healthcare provider and routine procedures outlined below for a period of one year from the date of signature. I also authorize the release of medical record copies to other agencies or physicians I may be referred to for additional care as deemed necessary by the attending provider.

During the course of my care and treatment, I understand that various types of tests and diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professions ("Healthcare Professionals") as medically necessary. While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis, or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

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COMPLIANCE WITH POLICIES: I agree to comply with all Health System policies including the "No Smoking" policy.

INDEPENDENT CONTRACTORS: Many of the physicians, dentists, oral surgeons, podiatrists and psychologists at the Gwinnett Hospital System are independent contractors of the Hospital and are not its employees or agents. As independent contractors, the physicians, dentists and oral surgeons, podiatrists and psychiatrists are responsible for their own actions. I understand that I may receive separate bills for their services.

REQUESTS FOR SPECIAL ASSISTANCE: Our staff wants to communicate effectively with you or other persons participating in your care or treatment who may be deaf/hearing impaired or have other special needs. Sign language and oral interpreters, TDD's (telecommunications device for the deaf), volume-control telephones, and other auxiliary aids and services are available free of charge to people who are in need of special assistance. Please contact the office manager for assistance with your needs.

I UNDERSTAND THAT: The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE MADE TO ME** concerning the outcome and/or result of any Procedures; that Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions; and I may withdraw my consent for any test or procedure at any time.

BY SIGNING THIS FORM:

I consent to Healthcare Professional performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and

I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

PATIENT NAME (print) _____ Date of Birth _____

SIGNED :_____ _____ _____

Patient/Patient's Representative Relationship Date

WITNESS_____

Reason if unable to sign: _____

Office Use Only:

Interpretive Service used on this encounter _____

Interpreter used – Name and number _____

Date/Time/Language _____