



Procedure Consent to Treat

1) On behalf of (print name) _____ patient/POA (circle one)

a) Agree that I/the patient will have (list procedure and body location):

b) At (name of facility) : _____

c) The reason for the procedure is: _____

d) This will be done by: _____

2) I/the patient have talked to my practitioner about:

a) What the procedure is and what will happen ____ (initial)

b) How it may help me/the patient (the benefits): Stimulate tissue growth, reduce infection, reduce pain, etc ____ (initial)

c) How it might harm me/the patient: Bleeding, damage to skin or underlying structures, infection ____ (initial)

d) Other choices for treatment and the risks/benefits of those treatments: Medical management: may delay healing ____ (initial)

3) I/the patient agree that:

a) I/the patient will ask questions ____ (initial)

b) No one has promised me/the patient definite results ____ (initial)

c) Pictures/video may be taken for medical and educational purposes only ____ (initial)

d) If a staff person is exposed to my blood or body fluids, my blood may be required to be drawn and tested for HIV and hepatitis. The test results will go:

To me/the patient (if positive)

To the exposed worker

To the Ohio Department of Health if positive

4) I/the patient understand that I can change my mind. If I do, I must tell my practitioner right away.

5) I/the patient have/has received written material and/or been verbally told about the procedure.

I give my informed consent and I agree to the procedure.

Signature: _____ Date: _____

Relationship to patient if signed by someone other than patient: _____

Provider signature: _____ Date: _____