Corewell Health™

Consent THERAPEUTIC PHLEBOTOMY

Patient Name

DOB

MRN

Physician

CSN

I give my consent for therapeutic phlebotomy procedure(s) or treatment(s) for the medical condition of _____

PROCEDURE

A therapeutic phlebotomy is a procedure where blood is drawn. A needle is inserted into a vein. This procedure is done to treat a number of conditions that have to do with having too much iron in the body.

RISKS/BENEFITS/OTHER OPTIONS

The risks include, but not limited to:

- Anemia
- Fatigue (feeling tired)
- Lower blood pressure
- Redness
- Vein irritation
- Dizziness
- Diaphoresis (clammy skin)
- Cardiac arrest which can result in life-threatening changes
- Pain or bleeding at the site

The possible benefits of therapeutic phlebotomy are _____

_____

_____

Other options to the procedure are _____

_____

_____

I have read this form or it has been explained to me. All my questions about this form have been answered.

_____ ☐AM ☐PM _____ _____
Time Date Patient Signature

_____ ☐AM ☐PM _____ _____
TIME **DATE** Witness to Signature

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I,_____, hereby certify that I am the _____ of the patient; that patient is unable to consent because patient is a minor, or because:

_____

_____ ☐AM ☐PM _____ _____
Time Date Signature of Parent, Legal Guardian, Patient Advocate or Next of Kin

_____ ☐AM ☐PM _____ _____
TIME **DATE** Witness to Signature

STATEMENT FOR INVASIVE PROCEDURES ONLY:

I have reviewed the patient consent form. The procedure for which the patient is consented conforms with the plan for this patient. I have discussed the risks, benefits and potential complications of the planned procedure, and the risks, benefits and potential complications of alternative treatments with the patient/family. The patient explained/taught back what he/she has recalled and understood from our discussion and wishes to proceed.

If the consent was signed more than 30 days prior to the procedure, I confirm there has been no material change in the patient's condition that may alter the risk of this procedure to the patient.

TIME _____ ☐AM ☐PM **DATE** _____ Physician signature _____ Pager number _____

INTERPRETING SERVICES:

I certify that I have interpreted, to the best of my ability, into and from the patient's stated primary language, everything said during the informed consent discussion.

TIME _____ ☐AM ☐PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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