SPECTRUM HEALTH

Consent THERAPEUTIC PHLEBOTOMY

Patient Name

DOB

MRN

Physician

FIN

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 _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present 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

X20393