I. PURPOSE: To ensure that any patient receiving surgery, dental surgery, or invasive medical procedures will be fully informed as to all risks, benefits, and alternatives prior to giving consent.

II. POLICY:

A. Patients undergoing any routine medical, dental or surgical procedures will be given full information as to the risks, benefits, and alternatives of the procedure by a person knowledgeable and experienced about the procedure. Appropriate informed consent will be obtained in all cases. If the patient is not competent to make such decisions, such information will be given to and consent obtained from the legally appointed guardian.

B. In case of medical emergencies where time is of the essence in saving the patient’s life, the above policy may not be followed, and the emergent needs of the patient are met with acceptable standards of medical practice.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. For all procedures performed at Montana State Hospital (MSH);

   1. The Medical Clinic Physician or Dentist is responsible for insuring that a signed “Informed Consent for Medical/Surgical Procedures” form is in the patient’s file prior to the beginning of the procedure.

   2. All other responsibilities are as per the procedure guidelines of the policy listed below.

V. PROCEDURE:

A. All surgical, dental, or medical procedures involving risk to the patient will require a signed “Informed Consent For Medical/Surgical Procedures” form before that procedure is begun.
B. All patients will be informed of the risks, benefits, and alternatives by the physician/dentist performing the procedure or a qualified designee familiar and knowledgeable about the procedure. The patient or legal guardian after being informed may sign the form. The signed informed consent form will become a part of the patient’s permanent file.

C. If the procedure is being performed at MSH, the “Informed Consent For Medical/Surgical Procedures” form will be prepared including:

1. The patient’s name and number;
2. The responsible party and their relationship to the patient;
3. The procedure to be performed;
4. The physician or dentist who will perform the procedure;
5. A statement as to why the procedure is necessary.

D. If the procedure is not being performed at MSH, a form will be completed stating the patient’s name and number, the responsible party, and their relationship to the patient, whether or not the patient is competent to make decisions about medical treatment, and if the patient is not competent, the name of the guardian along with the guardian’s address and phone number. MSH staff may assist by calling the guardian and preparing them for a phone call from the person performing the procedure, and making certain that person will be available at certain times so as to expedite the obtaining of an informed consent form by the provider of the service. The provider is responsible for obtaining a signed consent form for patients treated outside MSH.

E. If the procedure involves contrast material being injected into the patient’s body, an additional informed consent for contrast material is required.

VI. REFERENCES: None

VII. COLLABORATED WITH: Medical Staff and Medical Clinic.


IX. DISTRIBUTION: All hospital policy manuals.
X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Medical Director

XII. ATTACHMENTS:

A. Informed Consent for Medical/Surgical Procedures Form
B. Consent Information Form

___________________________/___/__
John W. Glueckert           Date           Thomas Gray, MD           Date
Hospital Administrator      Medical Director
MONTANA STATE HOSPITAL
INFORMED CONSENT FOR MEDICAL/SURGICAL PROCEDURES

I, ____________________________, a resident of _________________________ being (the _________________________ of _________________________), a patient of Montana State Hospital, do hereby give my consent to Dr. ___________________ of Montana State Hospital to perform

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I have discussed the above procedure with my physician, Dr. __________________, who has explained to me, to my satisfaction, the details and the reason for doing the procedure. I have also been explained and have understood the possible complications associated with the procedure which can include ______________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Any other alternatives have been discussed with me. I understand that the anesthesia used will be determined by my physician. I authorize the hospital staff to examine and to preserve for scientific purposes or otherwise to dispose of any tissues or parts which may be removed. I am aware of the risks associated with this procedure and I hereby relieve the State, the Chief Executive Officer/Medical Director and the physician(s) performing the procedure of all responsibility for any unfavorable outcome in the course of or resulting from this surgery. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

__________________________________  ______________________________________
Witness                                Signature of patient/guardian

__________________________________  ______________________________________
Date                                    Signature of Physician

MSH-AM-31-R-03-01
MONTANA STATE HOSPITAL
CONSENT INFORMATION FORM

*Note to provider: The following information is provided to aid you in obtaining informed consent for patients referred to you by Montana State Hospital.

PATIENT’S NAME: ________________________ HOSPITAL #: _______

GUARDIAN:

________________________
Name

________________________
Relationship to Patient

________________________
Address

________________________
Phone Number

Responsible Party

________________________
Name

________________________
Address

________________________
Phone Number

Montana State Hospital Contact:

________________________
Name

________________________
Phone Number

COMPETENCY STATEMENT

The above-named patient is being transferred to ________________________
Name of Hospital/Physician

for ________________________ procedure/treatment

____  He/She is competent to give consent for the procedure/treatment

____  He/She is not competent to make medical decisions and has been assigned a guardian.

_____________  ____________
Date Psychiatrist’s Signature

MSH-ADM-31-R-12-04