



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

PROCEDURE FOR OBTAINING INFORMED CONSENT FOR MEDICAL & SURGICAL PROCEDURES

Effective Date: April 21, 2016

Policy #: PH-07



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- 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.

VIII. RESCISSIONS: #PH-07, Procedure for Obtaining Informed Consent for Medical and Surgical Procedures dated February 14, 2009; #PH-07, *Procedure for Obtaining Informed Consent for Medical and Surgical Procedures* dated August 22, 2006; #PH-07, *Procedure for Obtaining Informed Consent for Medical and Surgical Procedures* dated March 31, 2003; #PH-07, *Procedure for Obtaining Informed Consent for Medical and Surgical Procedures* dated February 14, 2000; HOPP #PH-04-96-R, Procedure for Obtaining Informed Consent for Medical and Surgical Procedures, dated September 1996.

IX. DISTRIBUTION: All hospital policy manuals.

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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. XI. FOLLOW-UP RESPONSIBILITY: Medical Director

XII. ATTACHMENTS:

A. [Informed Consent for Medical/Surgical Procedures Form](#)

B. [Consent Information Form](#)

_____/_____/_____
John W. Glueckert Date
Hospital Administrator

_____/_____/_____
Thomas Gray, MD Date
Medical Director

Patient Name: _____

MSH #: _____

**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

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