Patient Informed Consent

- ☐ Legacy Emanuel Medical Center
- ☐ Legacy Good Samaritan Medical Center
- ☐ Legacy Meridian Park Medical Center
- ☐ Legacy Mount Hood Medical Center
- ☐ Legacy Salmon Creek Medical Center
- ☐ Legacy Silverton Medical Center
- ☐ Randall Children's Hospital at Legacy Emanuel

Full Name of Patient:

(Place patient identification label in this box.)

Name of Procedure(s): Cardiopulmonary Testing

- ☐ Exercise stress testing
- ☐ Pharmacological stress testing
- ☐ Echo stress testing
- ☐ Cardiopulmonary stress testing
- ☐ Lexiscan
- ☐ Dobutamine
- ☐ _____

Licensed Independent Practitioner _____ will supervise the procedure(s) Other practitioners may assist with the procedure(s) as necessary.

Risks of the procedure(s) may include but are not limited to myocardial infarction, abnormal rhythm, fainting, risk of fall, death. If pharmacological agent used risks may include, but are not limited to: allergic reaction, difficulty breathing and/or abnormal blood pressure.

The procedure(s), risks and alternatives listed above were explained to me. I have been instructed regarding the risks, benefits, and side effects of the alternatives, including the possible results of not receiving care, treatment, and services. I have had the opportunity to ask questions and all of my questions about the procedure(s), risks and alternatives were answered to my satisfaction. I have been instructed regarding potential problems that might occur during my recuperation and the likelihood of achieving goals. I understand that, during the course of the procedure(s), unforeseen conditions may necessitate additional or different procedures than those listed above or discussed with me. I authorize the physician/credentialed provider and other practitioners to perform such other procedures as are, in their judgment, necessary and appropriate. I acknowledge that no warranty or guarantee was made to me as to the result or cure.

I CONSENT TO THE ABOVE PROCEDURE(S)

(Patient's Signature*) **(Printed Name)** **(Date and Time)**

Patient is unable to consent because _____ I therefore consent for patient.

(Authorized Consenter's Signature) **(Printed Name)** **(Relationship to Patient)** **(Date and Time)**

(Witness's Signature) ☐ [Only required for telephone consent] **(Printed Name)**

I EXPLAINED THE ABOVE PROCEDURE(S) TO THE PATIENT OR AUTHORIZED CONSENTER

(Licensed Independent Practitioner) **(Printed Name)** **(Date and Time)**

Place original form in chart. For procedures performed in Washington, provide a signed copy to the patient.

PRINT SAVE AS EMAIL RESET

Whenever possible, the patient should complete the consent process. In the event the patient is unable to consent due to age or a physical or mental condition, the consent form must be signed by a person the law recognizes as someone who may act for the patient.

The following individuals may sign the consent form:

Adult Patients: Patients 18 years or older who are not suffering from a physical or mental condition which prohibits them from understanding what they are doing.

Minor Patients: In Oregon, patients under the age of 18 years of age if they are: (a) married, (b) emancipated by court order or (c) 15 years of age or older and seeking hospital care, or diagnosis or treatment by a physician or dentist licensed by the State of Oregon. ORS 109.640. The physician or practitioner and the hospital are permitted to notify the parent or guardian regarding the treatment without the consent of the minor. ORS 109.650.

In Washington, patients under 18 years of age if they are (a) married to a person age 18 or older or (b) emancipated by court order.