Northern Light Health

☐ A.R. Gould Hospital
☐ Acadia Hospital
☐ Blue Hill Hospital
☐ C. A. Dean Hospital
☒ Eastern Maine Medical Center
☐ Inland Hospital
☐ Maine Coast Hospital
☐ Mercy Hospital
☐ Sebasticook Valley Hospital

PROCEDURE INFORMED CONSENT

Patient Identification

Northern Light Health and its affiliates (Northern Light Health) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. Northern Light Health does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 797 Wilson St., Suite 4, Brewer, ME 04412, 1-866-769-8363 **(telephone)**, 1-207-989-1420 **(fax)**, or at nondiscrimination@northernlight.org **(email)**. If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-986-6341 (ATS : 711).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-986-6341(TTY: 711).
Oromo (Cushite): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-986-6341 (TTY: 711).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-986-6341（TTY：711）。
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-986-6341 (TTY: 711).
Tagalog (Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-986-6341 (TTY: 711)
Cambodian (Khmer): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-986-6341 (TTY: 711)។
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-986-6341 (телетайп: 711).
Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-986-6341 (رقم هاتف الصم والبكم: 711).
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-986-6341 (TTY: 711).
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-986-6341 (TTY: 711) 번으로 전화해 주십시오.
Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-986-6341 (TTY: 711).
*Nilotic (Dinka): **PID KENE**: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-888-986-6341 (TTY: 711)*
Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-986-6341（TTY:711）まで、お電話にてご連絡ください。
Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-986-6341 (TTY: 711

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Procedure:

☒ Planned series of procedures (explain): Full mouth rehabilitation, fluoride, x-rays, silver or white fillings, stainless steel crowns, nerve treatment, extractions, tissue removal

Nature of Procedure: My provider has discussed with me the details of my medical condition, the nature of the proposed procedure, potential benefits, risks, and side effects of the proposed care, treatment and services, as well as those related to reasonable alternatives. My provider has discussed with me the risks of not receiving the proposed care, treatment or service.

Disposal of Tissues and Hardware: Tissues and Hardware surgically removed will be disposed of in accordance with standard hospital practice (including use in donor tissue banks).

Photographs: I authorize the hospital to make photographs, or electronically recorded images for my medical records and, if I am not identified, for purposes of quality monitoring or education.

Risks and Hazards: My provider has discussed with me the usual and most frequent risks and hazards of this procedure including but not limited to: loss of blood requiring a blood transfusion, infection, drug reaction, blood clots, cardiac arrest, or loss of life. Other(s) Swelling, pain, discomfort, nausea, vomiting

No Guarantee: My provider has represented to me that no guarantee has been made concerning the results of this surgery / procedure.

Extension of Operation: My provider has explained to me that during the course of the procedure conditions may be revealed, that may require a change or extension of the operation. I authorize such additional procedures as are necessary for my condition.

Assistant at Surgery: ☐ No Assistant Planned
☒ I understand that my provider may be using an assistant during all or specific, significant procedural tasks (e.g. opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues, etc.) The assistant will be: (name and credentials)_____

If not known at this time, the individual will be a: ☐Provider ☐ Physician Assistant ☐ RN-First Assist ☐CST-First Assist ☐Other _____
If the person named on this form is unavailable, my provider can substitute another provider to assist with this procedure.

Anesthesia:

☐ **Non Applicable**
☒ **Local Anesthesia**
☐ **Procedural Sedation:** I understand that the administration of sedation is recommended, so that my provider can perform the procedure. The benefit of sedation is greater comfort throughout the procedure. It has been explained to me that all forms of sedation and anesthesia involve some risks. I understand that no guarantees or promises can be made concerning the results of my procedure or the sedation technique administered. Complications with sedation can occur and include: inadequate sedation, the possibility of infection, bleeding, drug reaction, injury to blood vessels, loss of sensation, paralysis, stroke, brain damage, heart attack, or death. Alternatives to sedation, including no sedation at all or the administration of general anesthetic, have been explained to me.
☒ **Regional and/or General Anesthesia:**
I understand that a separate consent form will be completed.

Blood Transfusions:

Benefits: My provider has explained that I might need a blood transfusion. Blood transfusions may be required to correct anemia to bring enough oxygen to organs. Other parts of blood, such as platelets and plasma, are important in helping blood clot to prevent or stop bleeding. Every effort will be made to avoid transfusion when possible.

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Alternatives: My provider has explained that in some situations there are alternatives to transfusion from the community blood supply. These alternatives include clotting factor concentrates, non-human topical tissue adhesives and hemostatics, human topical hemostatics, iron therapy, erythropoietin, intraoperative hemodilution, intraoperative autologous blood salvage, post-operative blood salvage and volume expanders such as salt, protein (albumin) or starch solutions. My provider has discussed any questions I have related to alternatives. I understand that not all alternatives are available or appropriate for me.

Risks: Blood transfusions are associated with some risks. Risks include, but are not limited to, rare complications such as:

- A.I.D.S. (HIV) . . . . . one chance in 1.9 million transfusions
- Hepatitis C . . . . . one chance in 1 million transfusions
- Hepatitis B . . . . . one chance in 1 million transfusions
- HTLV I&II . . . . . one chance in 641,000 transfusions
- Death from an acute hemolytic reaction . . . . . one chance in 500,000 transfusions

Other complications that occur with a chance of between one in 2,000 and one in 20,000 transfusions include difficulty breathing due to fluid in the lungs and early removal of the transfused red cells by the body's immune system. Fever, chills, or hives may occur in as many as one in 100 transfusions.

I understand that the blood is from the community blood supply, donated by healthy volunteers. The blood is tested with very sensitive and accurate tests to screen for hepatitis, AIDS, and other diseases. I understand that these tests may not identify potentially unknown blood borne pathogens. Before blood is transfused, it is tested again to make sure it is the correct type.

Transfusion Consent: (Applies to red blood cells, platelets, plasma, and cryoprecipitate)

☒ Not discussed

☐ If this box is checked, I refuse blood transfusions for religious or other reasons and understand fully that on rare occasions, transfusion may be the only treatment that can prevent death. _____(initials)
If the patient refuses transfusion, refer to hospital-specific blood management policies.

☐ If this box is checked, I consent to transfusion of blood or blood components when the potential benefits of transfusion are greater than the risks. My consent for transfusion applies to the entire admission or encounter surrounding the procedure. _____(initials).

PERMISSION

Provider Explaining Procedure: _____ has explained all of the above to my satisfaction and understanding. All of my questions have been answered. I understand that I can rescind all or any part of this consent at any point in time and that this /these consent(s) remain(s) effective unless revoked by me.

I hereby authorize (Provider Explaining Procedure): _____or a member of his/her practice group to perform the procedures and operations as described on the front of this form.

_____ Date _____ Time _____
Signature Provider Explaining Procedure

_____ Date _____ Time _____
Patient Signature*

_____ Date _____ Time _____
(Parent or person legally authorized to consent)

_____ Date _____ Time _____
Witness / Confirmation of Signature

The patient signed in my presence or the patient acknowledged to me that the signature is the patient's signature.

* If patient signature cannot be obtained, indicate reason here:
_____
_____
_____
_____
_____
_____

*A parent/guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or other authorized representative. If a minor patient consented to his/her own care, the minor patient must sign this authorization form to release records related to that care. Indicate relationship of representative to patient.