

**Kids Choice Pediatrics LLC**  
2775 Cruse Road Ste 1801  
Lawrenceville, GA 30044

## **INFORMED CONSENT TO ROUTINE PROCEDURES/ TREATMENTS**

### **DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS**

1. I acknowledge and understand that, during the course of the my/my child's care and treatment , it is likely that various types of routine diagnostic and treatment procedures ("Procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s).
2. While these types of procedures are routinely performed in hospitals and doctors' offices without incident, there are certain risks associated with each of these procedures.
3. The physician or his/her associates or assistants are responsible for providing me with information about the procedures and for answering all of my questions. It is not possible to enumerate each risk for every procedure utilized in modern health care. However, the independent physicians who practice medicine at Kids Choice Pediatrics have attempted to identify the most common Procedures, their associated risks and possible alternatives. If I have further questions or concerns regarding these Procedures, I agree to ask my/my child's physician to provide additional information.
4. I further acknowledge and understand that my/my child's physician may ask me to provide a separate Informed Consent document (for example, for a surgical procedure), as well.

The Procedures referenced herein may include, but are not limited to, the following:

- a. Needle Sticks**, such as shots, injections, or intravenous injections (IV's). The risks associated with these types of procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions, or paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
- b. Radiographic Procedures**, such as x-ray, sonogram, mammogram, CT scans, MRI's, PET scans, bone density scans, ultrasounds, and/or other imaging studies. The risks associated with these types of Procedures include, but are not limited to, radiation exposure, muscular-skeletal injuries, and/or bruising. Apart from using an alternative type of radiographic procedures or refusal or treatment, no practical alternatives exist.
- c. Physical tests and treatments**, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures, etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of Procedures include, but are not limited to, reactions to the material(s) used, infection, bleeding, discomfort, muscular-skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or re-injury. Apart from using modified procedures and/or refusal of treatment, no practical alternatives exist.
- d. Medications / drug therapy**, which may be utilized in the care and treatment of patients. The risks associated with these types of Procedures include, but are not limited to, food-drug-herbal interactions; allergic reactions; adverse reactions; and both long-term and short-term side effects which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.

- e. **Laboratory testing** which may be utilized when taking samples of blood, bodily fluids, and tissues samples for laboratory analysis. The risks associated with these types of Procedures include, but are not limited to, injuries which may occur during the collection of the necessary samples, infection, nerve damage, bleeding, bruising, paralysis, loss of limb, tingling or burning, swelling, allergic reactions. Apart from refusal of treatment, no practical alternatives exist.
  - f. **Internal tubes** such as catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The risks associated with this type of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.
5. I consent to and authorize the persons participating in and responsible for my/my child's care to utilize the procedures, such as those set forth above, as they may deem reasonable necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.
6. **By signing this form, I acknowledge and understand that I have been informed in general terms of the following:**
- a. The nature and purpose of the procedure(s);
  - b. The material risks of the procedures(s); and
  - c. The practical alternatives to such procedure(s).

If I have further questions or concerns regarding these procedures, I agree to ask my/my child's physician to provide additional information.

7. I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and /or result of any procedure(s).
8. I understand that physician, medical personnel and other assistants participating in the patient's care will rely upon the patient's documented medical history, as well as other information obtained from the patient, the family or others having knowledge regarding the patient, in the determining whether to perform the procedure(s) or the course of treatment for my/the patient(s) condition and in recommending the procedure.

**BEFORE SIGNING YOU MUST READ THE FRONT & BACK OF THIS FORM**

\_\_\_\_\_  
Signature of the Adult Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

Reason Adult Patient/Parent/Legal Guardian Unable to Sign, if applicable:

\_\_\_\_\_