CONSENT FOR TREATMENT WITH MEDICATION: REGLAN

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

I, _____, am a patient of _____.

I have been informed of my illness and advised to receive the medication metoclopramide hydrochloride, brand name Reglan, which is a dopamine antagonist.

I have been informed of the nature of the treatment and understand risks and possible side effects; including but not limited to allergic reaction, muscle spasms of your arms, legs, lips, jaw, tongue, face, or other body part; anxiety, agitation, jitteriness, shortness of breath, or insomnia; depression, yellowing of eyes or skin, changes in vision, irregular heartbeat, seizures or hallucinations. Minor, less serious side effects may be nausea, diarrhea, dizziness, drowsiness, headache, confusion, fluid retention, breast tenderness or swell, changes in menstrual cycle and increased frequency of urination. If prescribed Reglan, I specifically understand the risk of tardive dyskinesia, which may cause involuntary tic-like movements in my face, tongue, neck, arms and/or legs, and which may persist even after treatment with the medication has been stopped.

I understand that although my health care provider has explained to me the most common side effects of this treatment, there may be other side effects, and that I should promptly inform my health care provider or another member of the staff if there are any unexpected changes in my condition.

I understand that I may discontinue this medication if I choose, but I should inform my health care provider before doing so. I also understand that although my health care provider believes that this medication will help me, there is no guarantee as to the result that may be expected. I have been informed of the risks of refusing the recommended treatment. I have been informed that refusing medication does not prevent me from receiving other types of treatment.

On this basis, I authorize my health care provider or anyone authorized by my health care provider to administer the above-named medication at such intervals as deemed advisable.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

REFUSAL

I have been advised to take the medication(s) listed above but I am unwilling to take the medication as recommended. The possible consequences of not taking the medication have been explained to me. Specifically:

_____

_____

_____

SIGNATURE OF PROVIDER _____ DATE _____

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

SIGNATURE OF 2ND WITNESS _____ DATE _____

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CONSENT FOR TREATMENT

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

INFORMED CONSENT

I request _____ to perform upon me the following procedure(s):

_____

_____

If during the course of the procedure(s), the discovery of unforeseen conditions requires, in the judgment of the persons described above, different procedure(s) than those planned, I authorize such different procedure(s) as are deemed appropriate.

I understand that no warranty or promise has been made to me regarding the outcome of the proposed procedure(s) or cure of any condition, and the risks presented by the proposed procedure(s) or cure of any conditions. The risks presented by the proposed procedure(s), have been explained to me by _____ as have been the alternatives to the procedures planned.

I consent to the administration of anesthesia and to the use of such anesthetic agents and as may other drugs be deemed necessary and advisable, and understand that anesthesia and other drugs present additional risks and hazards.

I consent to the examination and disposal of any tissues, parts, or organs which may be removed as a result of the procedure(s) authorized at above facilities.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedure(s) to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. I have read, or have had read to me, this form and I understand its contents.

_____

_____

_____ _____

Inmate Date Witness to Signature Only Date Time

I have explained the matters indicated above relating to the operation and/or procedure and the risks, consequences and alternatives. The inmate appeared to understand and consented to the procedures described.

_____ _____

Physician's Signature Date

CONSENTIMIENTO INFORMADO
Informed Consent

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Solicito a _____ que realice sobre mi persona el/los procedimiento(s) que se detalla(n) a continuación:

_____

_____

Si durante el curso del/los procedimiento(s) se descubren condiciones imprevistas que requieren a criterio de las personas que se mencionan anteriormente la realización de otro(s) procedimiento(s) distinto(s) del/los planeado(s), autorizo que se lleve(n) a cabo el/los procedimiento(s) que se considere(n) adecuado(s).

Entiendo que no me garantizan ni prometen el resultado del/los procedimiento(s) propuesto(s) o la cura de ninguna enfermedad, así como tampoco los riesgos que se presentan al realizar el/los procedimiento(s) propuesto(s) o la cura de alguna enfermedad. _____ me explicó los riesgos presentados por el/los procedimiento(s) propuesto(s), al igual que las alternativas al/los procedimiento(s) planeado(s).

Expreso mi consentimiento al suministro de anestesia y al uso de los elementos que la anestesia comprende así como también todo otro medicamento cuyo suministro pueda considerarse necesario y aconsejable. Asimismo, entiendo que la anestesia y demás medicamentos presentan riesgos y peligros adicionales.

Expreso mi consentimiento para que se examinen y se dispongan de mis tejidos, partes, u órganos que se puedan extraer como resultado del/los procedimiento(s) que se autorizó/autorizaron en las instalaciones descritas anteriormente.

Tuve la oportunidad de formular preguntas sobre mi estado, formas alternativas del suministro de anestesia y tratamiento, riesgos que surjan al no seguir un tratamiento, el/los procedimiento(s) que se llevarán a cabo, y los riesgos y peligros que ello implica; además, creo que obtuve la información necesaria para poder manifestar mi consentimiento informado. Leí o me leyeron el presente formulario y entiendo su contenido.

_____

_____

Paciente _____ Fecha _____ Witness to Signature Only _____ Date _____ Time _____

I have explained the matters indicated above relating to the operation and/or procedure and the risks, consequences and alternatives. The inmate appeared to understand and consented to the procedures described.

Physician's Signature _____ Date _____

Consent to Test for HIV Antibody

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

1. I, _____
   (Last Name) (First) (MI)
   am asking Correct Care Solutions to test me for the presence of the antibody to the HIV/HTLV-III virus which causes Acquired Immune Deficiency Syndrome (AIDS). I have also been advised that this test requires withdrawal of a small amount of blood for laboratory testing.

2. I understand that the test results will be placed in my medical record and that persons involved in my direct care will have access to this information.

3. I have been informed that the HIV test results are considered confidential. I have been informed by the Medical Staff that the test results can not be released without my ***written permission***, except to individuals and organizations that are allowed to receive it by State law, Departmental Regulation.

4. Any questions I have regarding the nature of the blood test, its risks, or the consequences of placing the test results in my medical record have been answered to my satisfaction.

5. I acknowledge that I have read this consent form. I have been given the opportunity to ask questions concerning the blood test for HIV and my questions, if any, have been answered to my satisfaction. I understand the limitations of this testing procedure and the legal and emotional risks of taking the test. Accordingly, I do agree freely and voluntarily to be tested.

Signature of Inmate	Inmate Number	Date
Signature of Pre-Test Counselor	Date	
Signature of Person Collecting Specimen	Date	Specimen Number
Signature of Post-Test Counselor	Date	
Interpreter Signature, if Applicable	Date	

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revised 1/1/08

CONSENTIMIENTO PARA REALIZAR LOS ANÁLISIS PARA DETECTAR LA PRESENCIA DEL ANTICUERPO DEL VIH
Consent to Test For HIV Antibody

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

1. Yo, _____
(Apellido) (Primer nombre) (Segundo nombre)
solicito a Correct Care Solutions que me haga la prueba correspondiente para detectar la presencia del anticuerpo del virus del VIH/HTLV-III que causa el Síndrome de Inmuno Deficiencia Adquirida (SIDA). Asimismo, ellos me notificaron que dicha prueba requiere la extracción de una pequeña cantidad de sangre para que el laboratorio realice el análisis.

2. Comprendo que los resultados de los análisis se archivarán en mi historia clínica y que las personas que están a cargo de forma directa de mi cuidado tendrán acceso a dicha información.

3. Me informaron que los resultados de los análisis de VIH se consideran de carácter confidencial. Me informó el Personal Médico que los resultados de los análisis no pueden divulgarse sin mi ***autorización por escrito***, con la excepción de las personas de existencia visible o ideal autorizadas por la legislación del Estado, Normativa Departamental a recibir los mencionados resultados.

4. Todas mis preguntas con respecto a la naturaleza de los análisis de sangre, sus riesgos, o las consecuencias de archivar los resultados de dichos análisis en mi historia clínica fueron respondidas satisfactoriamente.

5. Acepto que leí el presente formulario. Tuve la oportunidad de formular preguntas referentes a los análisis de sangre de VIH; así mismo, mis preguntas, si hubo alguna, fueron respondidas satisfactoriamente. Comprendo las limitaciones del mencionado procedimiento de análisis y los riesgos emocionales y legales que implica llevar a cabo los análisis. Por consiguiente, acepto con plena libertad y voluntad que me hagan dichos análisis.

Firma del paciente - Inmate Signature	Número del paciente	Fecha
Signature of Pre-Test Counselor	Date	
Signature of Person Collecting Specimen	Date	Specimen Number
Signature of Post-Test Counselor	Date	
Interpreter Signature, if Applicable	Date	

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revised 4/23/08

Dental Informed Consent

Patient Name	*Patient Number*	*Date of Birth*	*Today's Date*

This is my consent for (procedure) : ☐Diagnostic X-Ray ☐Oral Examination ☐Scaling
☐Restorations ☐Extractions-Tooth Number _____
Patient Initial _____

☐Other, as deemed necessary by the dentist: _____

_____

I agree to the use of local anesthesia.

The frequency of complications associated with oral surgery is very low. However, with any surgical procedure there are certain post-operative occurrences, which you may or may not experience depending upon the nature of the procedure to be performed.

These may include, but are not limited to:

COMMON	INFREQUENT
* DRY SOCKET	* INFECTION
* PAIN	* PROLONGED SWELLING
* SWELLING	* HEAVY BLEEDING
* TEMPORARY MILD OOZING OF BLOOD	* TEMPORARY OR PERMANENT NUMBNESS OF LIPS AND/OR TONGUE
* SLIGHT ELEVATION IN TEMPERATURE	
* SKIN DISCOLORATIONS	* ORAL SINUS OPENING AFTER EXTRACTION OF UPPER TEETH
* LIMITED MOUTH OPENING	
*NAUSEA	* BROKEN FILLING IN ADJACENT TOOTH
* DIFFICULTY	* BROKEN ADJACENT DECAYING TOOTH

Under certain Circumstances, special X-rays may be required.

Medications and anesthetics may cause drowsiness.

I understand that I may ask any questions about my surgery and alternatives, arid will be given a detailed explanation before the procedure.

I acknowledge that all the information given in my medical history is correct.

NAME OF INMATE (PRINT)_____

_____ _____
Inmate Date Witness to Signature Only Date Time

I have explained the matters indicated above relating to the operation and/or procedure and the risks, consequences and alternatives. The inmate appeared to understand and consented to the procedures described.

_____ _____
Physician's Signature Date

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Influenza Vaccine Consent Form

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I have read the Vaccine Information Statement (VIS) for Inactivated Influenza Vaccine and have been given the opportunity to ask questions regarding the Influenza Vaccine and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that Influenza Vaccine be given to me.

Please answer the following questions:

	Yes	No
Have you ever had a serious allergic reaction to eggs?	_____	_____
Have you ever had a serious allergic reaction to a previous dose of influenza vaccine?	_____	_____
Have you ever had Guillain-Barre Syndrome (GBS)?	_____	_____
Are you pregnant?	_____	_____
Are you nursing at the present time?	_____	_____
Are you moderately or severely ill at this time?	_____	_____

_____ _____

Inmate/Patient Signature Date

_____

Vaccine administration date: _____

Manufacturer: _____ Lot # _____

Site of injection: _____

_____

Signature and title of Vaccine Administrator

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Formulario de consentimiento para la vacunación contra la gripe
Influenza Vaccine Consent Form

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Leí la hoja informativa sobre vacunas ("VIS", según su sigla en inglés) que trata sobre la vacuna inactiva contra la gripe y tuve la oportunidad de formular preguntas relacionadas con la vacuna contra la gripe, las que fueron respondidas satisfactoriamente. Creo que entiendo los beneficios y riesgos de la vacuna; por ello, solicito que me apliquen la vacuna contra la gripe.

Por favor, responder las siguientes preguntas:

	Sí	No
¿Alguna vez tuvo alguna reacción alérgica grave a los huevos?	_____	_____
¿Alguna vez tuvo una reacción alérgica grave a una dosis previa de la vacuna contra la gripe?	_____	_____
¿Alguna vez contrajo el Síndrome de Guillain-Barré (GBS)?	_____	_____
¿Está embarazada?	_____	_____
¿Está amamantando en la actualidad?	_____	_____
¿Tiene alguna enfermedad leve o grave en la actualidad?	_____	_____

_____ _____

Firma del paciente Fecha

Vaccine administration date: _____

Manufacturer: _____ Lot # _____

Site of injection: _____

_____

Signature and title of Vaccine Administrator

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Refusal of Treatment

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I, _____ have, this day, knowing that I have a condition requiring
(Name of Patient)

medical care as indicated below:

_____ A. Refused medication
_____ B. Refused dental care
_____ C. Refused an outside medical appointment
_____ D. Refused laboratory services
_____ E. Refused X-Ray service
_____ F. Refused other diagnosis services
_____ G. Refused physical exam
_____ H. Other (Please specify)

_____

_____

Reason for Refusal _____

_____

_____

Potential Consequences Explained:

_____A. Worsening Of Medical Conditions
_____B. Death
_____C. Permanent Disability
_____D. Other _____

I acknowledge that I have been fully informed of and understand the above refused treatment and the risks involved in refusing. I hereby release and agree to hold harmless CCS and correctional personnel from all responsibility and any ill effects which may result from this refusal.

I have read this form and certify that I understand its contents.

_____
Witness Signature

_____
Witness Signature

_____
Patient Signature

_____
Date

_____
Time

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Rechazo del Tratamiento
Refusal of Treatment

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Yo, _____ -en esta fecha- sabiendo que
(Nombre del paciente)
tengo una enfermedad que requiere tratamiento médico procedo de la siguiente forma:

___ A. Rechacé medicamentos - Refused Medication
___ B. Rechacé asistencia odontológica - Refused dental exam
___ C. Rechacé una consulta con un médico externo – Refused an outside medical appt
___ D. Rechacé someterme a análisis de laboratorio – Refused laboratory services
___ E. Rechacé estudios de radiografías – Refused X-Ray service
___ F. Rechacé otras formas de determinar mi diagnóstico – Refused other diagnostic service
___ G. Rechacé realizarme un examen físico – Refused physical exam
___ H. Otros (Por favor, indíquelos) – Other (please specify)

_____

_____

Motivos de mi rechazo (Reason for Refusal):_____

_____

_____

_____

Consecuencias futuras que se explicaron (Potential Consequences Explained):

_____ A. Empeoramiento de las condiciones médicas - Worsening of medical condition
_____ B. Muerte - Death
_____ C. Discapacidad permanente – Permanent Disability
_____ D. Otras – Other _____

Reconozco que se me informó plenamente sobre los tratamientos que rechacé anteriormente y sobre los riesgos que ello implica y que entiendo al respecto. Por medio del presente eximo de toda responsabilidad a CCS y al personal correccional que pueda derivar de los efectos de la enfermedad como consecuencia de mi rechazo.

Leí el presente formulario y certifico que comprendo su contenido.

_____
Witness signature

_____ _____
Witness signature Firma del paciente

_____ _____
Fecha (Date) Hora (Time)

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Authorization for Release of Information
AUTORIZACION PARA DIVULAR INFORMACION

Patient Name	*Patient Number*	*Date of Birth*	*Today's Date*
AKA(Alias):	*Booking Number*		*Social Security No:*

I Authorize / Autorizo:	To Release Information To / A divulgar Información a:
Name of organization or individual / Nombre	Name of organization or individual / Nombre
Address / Dirección	Address / Dirección

1 This authorization includes records relating to the following (please check) / La presente autorización comprende los registros relacionados con lo que se detalla a continuación (por favor, marque la opción correcta):

- ☐ All remaining records / Otros registros restantes ☐ Specify / Especificar _____
- ☐ Mental health treatment / Tratamiento de salud mental
- ☐ Chemical dependency treatment / Tratamiento de drogadicción o alcoholismo
- ☐ HIV or AIDS related tests and treatment / Tratamiento o pruebas de SIDA o VIH

2 Purpose for disclosure (this line must be completed) / Propósito de la divulgación (se debe completar este renglón):_____

3. Indicate dates of interest / Indique las fechas importantes. _____
If no date-range is provided, release will cover the previous year only / Si no se indica el periodo de divulgación, la misma tendrá lugar sólo por el término del año anterior.

4. I understand that I may revoke this authorization at any time by providing written notice, except to the extent that release of information has already occurred in reliance upon it.

5. I understand that under Federal Law (42CFR Part 2) records relating to treatment for chemical dependency cannot be released without my specific authorization as indicated under "1."

6. I understand that information disclosed under this authorization may not be disclosed again by the recipient without my approval other than as authorized by state and federal laws.

7. I understand that I will receive treatment even if I refuse to provide approval, but also understand that refusing to authorize information may affect the nature of the treatment provided.

8. I agree to hold harmless all persons acting upon this authorization in good faith.

9. It is my intention that a photocopy will be as valid as this original.

10. This authorization shall be valid for one year from the date of my signature.

4. Comprendo que puedo revocar la presente autorización en cualquier momento siempre que notifique mi decisión por escrito, salvo que la divulgación de mi información se haya efectuado dependiendo de dicha autorización.

5. Comprendo que conforme a la Ley Federal (42CFR – Código de Normativa Federal – Parte 2) los registros relacionados con el tratamiento para el alcoholismo o drogadicción no pueden divulgarse sin mi previa autorización específica tal como indica el punto "1."

6. Entiendo que la información que se divulgue en relación a mi autorización no puede ser revelada nuevamente por la parte receptora de la misma sin mi debida aprobación tal como lo indican las leyes estatales y federales.

7. Comprendo que recibiré tratamiento incluso si me niego a otorgar mi aprobación; pero, asimismo comprendo que rehusarme a autorizar la divulgación de mi información puede afectar la naturaleza del tratamiento que se me proporcione.

8. Acepto eximir de responsabilidad a todas las personas que actúen con buena fe bajo la presente autorización.

9. Manifiesto que una fotocopia tendrá el mismo valor que su copia original.

10. La presente autorización tendrá validez por el plazo de un año a partir de la fecha de mi firma.

Patient or authorized signature / Firma del paciente o persona autorizada	Date / Fecha
If other than patient signature, relationship to patient / Si no es la firma del paciente, indicar relación con el paciente	Date / Fecha
Witness signature / Firma del testigo	Date / Fecha

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