Russell Medical
MEMBER OF UAB HEALTH SYSTEM

Patient Consent to Wound Care Treatment

Note: This form is to be signed by all Wound Care Center Patients receiving evaluation and management services. If the Patient is scheduled to undergo a procedure (e.g., Hyperbaric Oxygen Therapy, Cellular Tissue Based Products, or other advanced interventions), the appropriate approved procedural consent form must also be executed

Patient Name ("Patient"):_____ Date of Birth: _____

Hospital ("Hospital"):_____

You have the right to be informed about your condition and any recommended medical procedures so that you can make an informed decision about whether to undergo the proposed treatment after understanding the potential risks and benefits. By signing this consent, the patient voluntarily agrees to receive wound care treatment provided by the Hospital and its contractor Healogics, LLC. ("Healogics") along with their respective employees, agents, representatives and affiliated companies (collectively referred to as the Wound Care Center ("WCC")). The patient understands that this consent remains in effect from the date it is signed until the patient is discharged from care, treatment, and services at the WCC. A new consent will be obtained if the patient is discharged and later returns for additional care, treatment, or services. The patient understands that they have the right to give or refuse consent for any proposed procedure or treatment at any time before it is performed. If a patient is unable to consent to treatment due to incapacity or age, the term "patient" in this document refers to the legal representative who is authorized to act on behalf of the individual receiving treatment.

1. **General Description of Patient's Medical Condition and Wound Care Treatment:** Patient acknowledges that Physician/Advanced Practice Clinician (APC) has explained Patient's general medical condition to patient. Patient further acknowledges that Physician/APC has informed Patient that Patient's treatment in the WCC may include, but is not be limited to, debridements, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as blood, urine and other studies), x-rays, hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a Physician/APC. Patients acknowledge that Physician/APC has given Patient the opportunity to ask questions about treatment, Patient has asked any questions Patient has about treatment, and Physician/APC has answered all of Patient's questions regarding treatment that may be provided to Patient in the WCC.
2. **Benefits of Wound Care Treatment:** Patient acknowledges that Physician/APC has explained the potential benefits of treatment in the WCC, including enhanced wound healing and reduced risks of amputation and infection.
3. **Risks and Side Effects of Wound Care Treatment:** Patient acknowledges that Physician/APC has explained that treatment in the WCC may cause side effects and involve risks including, but not limited to, infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissues, possible damage to organs, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin preparation solutions, removal of healthy tissue, and prolonged healing or failure to heal.
4. **Likelihood of achieving goals:** Patient acknowledges that Physician/APC has explained that, by following Physician/APC's plan of care, Patient is more likely to have a favorable outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Patient specifically acknowledges and agrees that no representation made to patient by Physician/APC, Hospital or Healogics constitutes a Warranty or Guarantee that Patient will experience any result or cure.

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5. **Refusal of WCC Treatment:** Patient acknowledges that Patient has been made aware that Patient may refuse any or all treatment in the WCC. Patient acknowledges that, if Patient refuses treatment in the WCC, Patient will not receive certain advanced wound care therapies that might benefit the patient.
6. **Alternative to WCC Treatment:** Patient acknowledges that Patient has been made aware that, in lieu of treatment in the WCC, Patients may continue a course of treatment with Patient's personal Physician/APC or may decide not to seek further treatment. Patients acknowledge that Physician/APC has explained that, if Patient chooses to continue a course of treatment with Patient's personal Physician/APC or forego any treatment, Patient may not experience the risks and/or side effects associated with treatment in the WCC. Patient may experience prolonged healing or failure to heal, infection, and possible amputation if Patient's wound is on one of Patient's limbs.
7. **General Description of Wound Debridements:** Patient acknowledges that Physician/APC has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment in the WCC, multiple wound debridements may be necessary and will be performed by an authorized Physician/APC.
8. **Risks and Side Effects of Wound Debridement:** Patient acknowledges that Physician/APC has explained the risks or complications of wound debridement include, but are not limited to, scarring, damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin preparation solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that Physician/APC has explained that bleeding after debridement may cause a patient who is already in poor health to get worse more rapidly than if the debridement had not been performed. Patient specifically acknowledges that Physician/APC has explained that drainage of an abscess or debridement of necrotic (dead) tissue may cause bacteria and bacterial toxins to be released into the bloodstream and cause severe sepsis or septic shock. Patient specifically acknowledges that Physician/APC has explained that debridement will make Patient's wound larger due to the removal of dead tissue from the edges of the wound.
9. **Patient Identification and Wound Images:** Patient understands and consents to having recordings or images (digital, film, images, videos, digital, electronic, or audio media, etc.), taken of Patient and Patient's wounds with their surrounding anatomical features. These images are taken for treatment purposes, including for the ability to monitor the progress of wound treatment and to provide for continuity of care. The images may be considered protected health information (PHI) and will be handled, maintained, and retained in a confidential, secure, and protected manner in accordance with applicable laws, regulations, and Hospital privacy and retention policies. Patient understands that the Hospital will retain ownership rights to these images and Patient expressly waives any and all rights to royalties or other compensation for these images. Patient understands that Patient may view or obtain copies of the images in accordance with applicable laws, regulations, and policies.

Patient hereby acknowledges that Patient has read this document or had it read to him or her, understands and agrees to the information in this document, and has had the opportunity to ask questions and receive answers to questions about this document and the information in this document. By signing below, Patient consents to the care, treatment, and services explained to patient by Physician/APC and described in this document and consents to the creation of images of Patient's wounds...

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Patient Signature or parent (if minor)	Relationship	Date	Time
Witness Signature		Date	Time

Interpreted by: _____ (if applicable)

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

Legal Guardian or Legal Representative	Date	Time

Printed Name: _____ Relationship: _____

The undersigned Physician/APC has explained to patient (or Patient's legal representative), the nature of Patient's proposed treatment or procedure(s), reasonable alternatives to such treatment or procedure(s), likelihood of achieving Patient's goals with regard to such treatment or procedure(s), and the potential benefits, risk, side effects, complications and consequences relating to such proposed treatment or procedure(s).

Printed Name of Physician/APC

Signature of Physician/APC	Date	Time

Patient Initials: _____