Children's Hospital and Health System
Patient Care Policy and Procedure

This policy applies to the following entity(s):
☒ Children's Hospital and Health System

SUBJECT: Consent for Treatment

Table of Contents

POLICY

Children's Wisconsin (Children's) respects the right of patients/clients/parents/legal guardians to receive information in a manner that they can understand and to make informed and voluntary health care decisions.

Minor patients/clients should be informed of the proposed treatment, to the extent possible, taking into account age, maturity and condition. Social work may also be consulted in situations where the minor patient/client and/or parent/legal guardian is under significant stress, impacting ability to process information and think critically (i.e. presenting with anxiety, withdrawal, anger, dissociation, difficulty focusing, difficulty remembering things, etc.).

Emergent treatment should not be delayed to obtain informed consent if there is a substantial or immediate threat to the life or health of the patient/client.

PROCEDURE

I. Who Can Give Consent?

A. **Parent/Legal Guardian of a Minor:** For patients/clients under 18 years of age, the patient's/client's parent or court appointed legal guardian must consent. Generally, if the mother and father identify themselves as the parents of the child, they are both able to consent for the child. Generally, only one parent's consent is required with two exceptions. In end of life decisions, we generally try to obtain consent from both parents. Additionally, for gender affirming hormonal therapy involving pharmacologics, we generally try to obtain consent from both parents and legal guardian(s) as set forth in Section IV. D, below.

B. **Adult:** A patient/client 18 years of age or older has the right to consent to his/her own medical treatment. The patient/client must have the capacity to understand the medical information.
   1. If an adult is deemed to have incapacity by a court, the adult generally cannot consent to his/her own medical treatment and must have a legal guardian appointed by the court unless they previously executed a Healthcare Power of Attorney (POA) or Advance Directive.
   2. If an adult patient is deemed to have incapacity and they have executed a Healthcare POA/Advance Directive, refer to the Patient Care Policy and Procedure: Advance Directive for Adults.

C. **Authorized Representative of an Adult**: An adult may designate another adult to give informed consent.

D. **Other:** In certain circumstances, with acceptable documents, another caregiver or agency may be able to consent for specified medical care of a minor child; See Section XI below: "Government Forms".

II. Who Conducts the Informed Consent Discussion?

Informed Consent means a process in which the patient/client/parent/legal guardian is given information in a manner that he/she can understand, has the opportunity to ask questions, and agrees to the proposed treatment, procedure or to participate in research. During the informed consent process, the provider should inform the patient/client/parent/legal guardian about the availability of reasonable alternate medical modes of treatment and about the benefits and risks of these treatments. The provider should disclose information that a reasonable physician in the same

or similar medical specialty would know and disclose under the circumstances. Questions from parents, guardians and the patient shall be answered. (Wis. Stat. § 448.30).

A. The informed consent discussion should be conducted by the attending provider, other qualified provider, or their delegate who is performing the procedure. Qualified providers include fellows, residents, physician assistants, nurse practitioners, or other practitioners who have undergone medical staff or professional health care provider credentialing and are allowed to conduct the informed consent discussion to perform certain procedures through their training program or hospital job description.
B. It is recommended that the provider performing the informed consent discussion use a method to evaluate the individuals understanding of the discussion. One method that may be used includes the "teach back" method.
C. Any member of the health care team can reinforce or supplement the informed consent discussion by further explanations, teaching, and answering of questions within the scope of their discipline. Any questions outside their scope of knowledge should be referred to the provider.

III. Consent Documentation

A. Generally, consent is a two part process that involves:
   1. the provider having an informed consent discussion with parent(s) or legal guardian(s); and
   2. a written signature on the appropriate Children's consent form; See Section IV below: "Consent Forms and Duration of Consent"
B. The informed consent discussion must be documented by the provider in the electronic health record ("EHR") in addition to any required written consent form. The documentation should set forth which parent(s)/legal guardian(s) were present and the agreement for care/treatment/service, risks, benefits, alternatives of the service being provided, and any additional informed consent information.
C. For Fox Valley patients, a Children's nurse may assist with obtaining a signature from the parent/legal guardian on a ThedaCare consent form for procedures occurring at ThedaCare Regional Medical Center Neenah. The informed consent discussion should be performed by the ThedaCare provider.
D. See Section VII below: "Verbal Consent' for documentation of verbal consent.
E. Abbreviations; See Patient Care Policy and Procedure: Abbreviations.

IV. Consent Forms and Duration of Consent

A. **Consent for Treatment (single encounter) form**

The Consent for Treatment (single encounter) form should be utilized when a patient is seen in the Emergency Department/Trauma Center ("EDTC") or urgent care, requires hospitalization, or is scheduled for a procedure in surgery, day surgery, or short stay. The consent form is obtained at the time of arrival and is valid for the treatment provided during that specific encounter or for the duration of the hospitalization (See Appendix B).

B. **Outpatient Consent for Treatment (annual) form**
The Outpatient Consent for Treatment (annual) form should be utilized when a patient is seen for ambulatory, ancillary and primary care services. Ancillary services include laboratory, imaging and diagnostic services. Only one signed Outpatient Consent for Treatment (annual) form is required per year. A separate Outpatient Consent for Treatment (annual) form for each services is not required (See Appendix C).

C. **Consent by Minor for Reproductive Health Services form**
The Consent by Minor for Reproductive Health Services form may be used when a minor requests the following services be provided: contraceptive care, sexually transmitted disease testing and treatment, HIV testing (depending upon age, see HIV Testing and Disclosure of Results P&P), pregnancy testing, and other similar reproductive health services. This form is valid for that single encounter and limited to reproductive health services (See Appendix D) and/or See Administrative Policy and Procedure: Confidential Guarantor. Use of this form does not guarantee confidentiality of these services, and the minor should be informed of such.

D. **Consent for Procedure (without anesthesia services) form and Consent for Surgery/Procedure (with anesthesia services and blood) form**
1. The Consent for Procedure (without anesthesia services) form and Consent for Surgery/Procedure (with anesthesia services and blood) form should be used for all major therapeutic and diagnostic procedures where disclosure of significant medical information, including major risks involved would assist the patient/parent/legal guardian in making a decision whether to undergo the proposed procedure. Such procedures may include, but are not limited to, all surgical procedures performed under general anesthesia, major regional anesthesia, or deep sedation, selected procedures under local anesthesia with or without sedation.(See Appendix E and F)
2. The Consent for Surgery/Procedure (with anesthesia services and blood) form should generally be used when the surgery will occur in the following locations: operating room, special procedure room, Surgicenter of Greater Milwaukee, heart catheterization lab and interventional radiology department.
3. Generally, procedures outside of the areas mentioned in section D.2. above should utilize the Consent for Procedure (without anesthesia services) form if anesthesia services are not involved (procedural sedation or clinic treatments or procedures where specific informed consent discussions take place).
4. Departments may determine that a procedure consent form is needed based on level of risk. Departments should use the appropriate procedure consent form and include the type of medical procedure on the consent form.
5. Both consent forms are valid for 90 days from the date of the patient/parent/legal guardian signature as long as there is no change in the intended surgery or procedure, change in the provider performing the surgery or procedure, and the condition of the patient remains essentially unchanged from the time of the signature. Generally, the 90 days will be valid for most elective surgeries or procedures.
6. The consent for transfusion of blood or blood products that is within the Consent for

Surgery/Procedure (with anesthesia services and blood) form is valid for the length of the hospitalization; See Patient Care Policy and Procedure: Blood and Blood Components: Verification Procedure, Administration and Monitoring

E. **Multiple Procedures/Surgeries and Series Encounters**

1. A separate Consent for Procedure (without anesthesia services) form and Consent for Surgery/Procedure (with anesthesia services and blood) form for each surgery or procedure is generally necessary.
2. If the original consent form clearly indicates that the patient needs a continuing series of related operations, treatments (i.e. Botox injections) or surgical procedures, and the patient/parent/legal guardian understands and consents to those treatments, the original consent form may be used for no more than one year.
3. For continuing series or related operations, treatments or surgical procedures, it is recommended that a start and end date of no later than one year, is added to the consent form.
4. If any operation or treatment radically departs from the others in its nature or duration, a separate consent form should be obtained as evidence that the patient/parent/legal guardian understands the additional risks and benefits of the treatment and the nature of the additional consent, which he/she is giving.
5. If multiple providers will be performing different procedures/surgeries, it is generally recommended that each provider utilize a separate consent form. The form must include the name of the provider that is performing the procedure.

F. **Procedures/Surgery under Research Protocols**

A separate consent form needs to be obtained for any procedures performed for research purposes. Please contact the IRB office for further guidance; See IRB-Research: Conducting Research on Human Subjects at Children's Hospital and Health System.

G. **School Health Consent forms**

1. <u>School Health Consent for Treatment ("excluding medications")</u>
   A School Health Consent for Treatment ("excluding medications") form must be utilized to perform services in the school setting. The School Health Consent for Treatment ("excluding medications") form is valid for the duration of the student's enrollment with the school system or until the parent/legal guardian revokes the consent with the Children's school nurse. (See Appendix G).
2. <u>School Health Consent for Treatment ("essential oils")</u>
   A School Health Consent for Treatment ("essential oils") form must be utilized to perform services in the school setting. The School Health Consent for Treatment ("essential oils") form is valid through September 30th of the following school year once signed. (See Appendix G). See Patient Care Policy and Procedure: Essential Oil Use.

H. **Surgicenter of Greater Milwaukee ("Surgicenter") Consent form**

A Surgicenter Consent form must be utilized when a patient is having services at Surgicenter. The consent form is valid for that single encounter. (See Appendix H). A separate Consent

for Surgery/Procedure (with anesthesia services and blood) form or Consent for Procedure (without anesthesia services) must also be obtained.

I. **Consent for Outpatient Mental and Behavioral Health ("MBH") Treatment and Consent for Mental Behavioral Health Treatment (single encounter) forms**

1. A Consent for Outpatient Mental and Behavioral Health Treatment form should be obtained when a patient/client is seen for outpatient MBH treatment that will be ongoing in nature. The consent form is valid for a period of one year (See Appendix I).
2. If the visit will be a single encounter, such as services offered through MBH walk-in clinics (without ongoing treatment), the Consent for Mental and Behavioral Health Treatment (single encounter) should be used (see Appendix J). This consent form is valid for the treatment provided during that specific encounter. A new single encounter consent form should be used in the event there are subsequent follow up encounters.
3. Outpatient MBH treatment for a minor 14 years of age or older requires the consent of both the parent and the minor. Outpatient MBH treatment for a minor under 14 years of age requires the consent of the parent/legal guardian.
4. For verbal consent information, see section VII.B. Verbal Consent.

J. **Consent for Chiropractic Treatment**

The term of consent shall continue until the earliest of: completion of the course of treatment; revocation of consent; or one year from consent date. If any treatment plan radically departs from what was consented in its nature or duration, a separate consent form should be obtained as evidence that the patient/parent/legal guardian understands the additional risks and benefits of the treatment and the nature of the additional consent, which he/she is giving. (see Appendix K)

K. **Consent for Estradiol or Testosterone (Gender Affirming Hormone Therapy) form**

1. The Consent for Estradiol (Gender Affirming Hormone Therapy) form or the Consent for Testosterone (Gender Affirming Hormone Therapy) form should be used for patients seeking gender affirming care in the Gender Health Clinic. (See Appendix F and Appendix G, respectively)
2. Use of estradiol or testosterone for a minor under 18 years of age for gender affirming hormone therapy requires the consent of both parents, provided that neither parent's legal rights had been terminated, or the consent of the patient's legal guardian(s).
3. The term of the consent shall continue until the earliest of: completion of the course of treatment; revocation of consent; or termination of the treatment.
4. The patient's assent should be obtained in writing on the respective consent form, and the signed consent form and the assent/informed consent discussion should be documented in the patient's medical record following the assent/informed consent discussion.

L. **Consent for Puberty Blockers (Gender Affirming Hormone Therapy) form**

1. The Consent for Puberty Blockers for gender affirming care form should be used for patients seeking gender affirming care in the Gender Health Clinic. (See Appendix N)
2. Use of puberty blockers for a minor under 18 years of age for gender affirming care

requires the consent of both parents, provided that neither parent's legal rights had been terminated, or the consent of the patient's legal guardian(s).

3. The term of the consent shall continue until the earliest of: completion of the course of treatment; revocation of consent; or termination of the treatment.
4. The patient's assent should be obtained verbally and the discussion should be documented in the patient's medical record following the assent/informed consent discussion.

V. Consent Form Signatures and Witness

A. Generally, it is best practice for the signature on the consent form to be witnessed. The witness can be any staff member or any member of the health care team.
B. In Children's areas that accept electronic signatures, electronic signatures (parent/legal guardians and witness) can be accepted. The witness' electronic signature is located in the electronic health record, in the "received by" column in the documents list.
C. No witness is required for the following:
   1. consent forms signed electronically
   2. consent forms not signed in the presence of a member of a health care team
   3. school health consent for treatment form
D. Concerns during the signature and witness process:
   1. Staff should promptly notify the provider upon the occurrence of any of the following:
      a. there is a request for further information about a treatment or procedure that is beyond their scope of knowledge
      b. an individual refuses to sign the necessary consent form
      c. there is a disagreement between parents regarding the desired course of treatment
      d. there is a request to revoke a previously given consent
      e. circumstances under which the initial consent was given have significantly changed
      f. there is a reasonable belief that the individual signing the consent did not comprehend the proposed treatment or procedure
      g. the consent is modified by the individual signing the consent (adds, deletes words, changes the wording) ; See section VIII below: "Modifications/Changes/Additions to Consent Form"

VI. Faxed/Mailed Consent

Children's will accept a mailed or faxed copy of the consent form.

VII. Verbal Consent

A. Verbal consent may be obtained when it is not possible to obtain written consent. The verbal consent should be documented on the appropriate consent form, along with the witness signatures.
   1. If a second witness is present for the verbal consent, the verbal consent is valid for a maximum of 1 year.
   2. If a second witness is not available, the verbal consent is valid for that encounter only. If there are reasons that a second witness cannot validate the consent given over the

telephone, please indicate such on the witness line. For example: no witness available, emergency situation, etc.

B. For outpatient MBH treatment, if there is an emergency situation, or time and distance requirements preclude obtaining written consent before beginning treatment and a determination is made that harm will come to the patient if treatment is not initiated before written consent is obtained, verbal consent may be obtained to initiate services. Verbal consent in this instance is only valid for 10 days. Within 10 days after obtaining verbal consent, a signed consent form by the patient/client/parent/legal guardian is required.
C. Efforts to obtain written consent should be documented in the EHR
D. The staff should make a reasonable attempt to verify the parent/legal guardian's identity and authority. **[NOTE**: Concerns regarding legal authority or capacity to consent or unresolved disagreement between parents should be escalated to Social Work and ultimately the Risk Management department for further guidance. Such escalation and the outcome should be documented in the medical record by Social Work.]

VIII. Modifications/Changes/Additions to Consent Form

A. If any information required on the consent form is unknown at the time the form is to be executed, the signing should be delayed until all information is available.
B. Written changes by a patient/client (parent/legal guardian) are not permitted on any Children's consent forms.
   1. If an individual does not agree with certain elements of the consent form, they should discuss this with their provider.
   2. If an individual insists on making modifications to a consent form, contact Risk Management.
C. A provider may make a change on the Consent for Procedure (without anesthesia services) form and Consent for Surgery/Procedure (with anesthesia services and blood) form.
   1. This change should be initialed by the provider and the patient (parent/legal guardian).

IX. Withdrawal of Consent

A. The patient/client/parent/legal guardian may withdraw consent at any time. If this should occur, the patient/client/parent/legal guardian withdrawing consent should put the request in writing for HIM to follow up and the provider should be notified. Single encounter or Procedure consent forms cannot be revoked following the completed encounter or procedure.
B. Staff should document any requests to withdraw consent by a patient/client/parent/legal guardian in the EHR.

X. Parent/Guardian Refusal to Consent to Treatment or Blood Products

See Patient Care Policy "Refusal to Consent to Treatment or Blood Products".

XI. Government Forms

A. Wisconsin Delegation of Parental Powers Form

1. The Wisconsin Delegation of Parental Powers form allows parent (s) to delegate some parental powers of their minor child to another adult, called the agent.
2. When properly executed, the form gives the agent the ability to consent for/sign the

Outpatient Consent for Treatment form and the Outpatient Consent for Mental and Behavioral Health Treatment form.

3. A copy of the Delegation of Parental Powers form should be sent to EHR/HIM Data Integrity Analysts for review, patient contact changes as appropriate, and for scanning into the EHR.
4. The form should be reviewed because the parent can limit the ability of the agent to consent to certain treatments.
5. The agent delegated by the parent (s) must sign the appropriate Children's consent form (s).
6. The agent cannot consent for hospitalized patient care, or other care that requires a separate consent form (procedure/surgery, etc.). Children's generally will only accept this form for routine/ordinary outpatient care and outpatient MBH services, even if the form shows otherwise. Consult with Social Work for any questions.
7. The Wisconsin Delegation of Parental Powers form is valid for a period up to one year, unless the agent is a relative of the child (Wis. Stat. § 48.979).

B. Department of Children and Families Authorization to Medical Treatment Form

1. The Department of Children and Families Authorization to Consent to Medical Treatment Form allows parent (s) to delegate some parental powers to the Child Protective Services agency or to a foster parent/relative caregiver when a child is placed in out of home care.
2. When properly executed, the form gives the individual/agency delegated by the parent, the ability to consent for certain care and to sign the Outpatient Consent for Treatment form.
3. A copy of the Department of Children and Families Authorization to Medical Treatment form should be sent to EHR/HIM Data Integrity Analysts for review, patient contact changes as appropriate, and for scanning into the EHR.
4. The form should be reviewed because the parent can limit the ability of the individual/agency to consent to certain treatments.
5. The individual/agency delegated by the parent must sign the appropriate Children's consent form (s).
6. The form cannot be used for hospitalized patient care, mental health assessment or treatment, or other care that requires a separate consent form (procedure/surgery, etc.).

C. Other Forms (Local/Out of State)

When properly executed by a parent/legal guardian, Children's may accept other forms. The forms may be sent to Riskmngmnt@childrenswi.org during business hours for review. Forms approved by Risk Management may allow an adult delegated by the parent/legal guardian to consent for certain care and to sign a Children's consent form.

XII. Special Situations

A. Emergency Treatment

Emergency treatment can be provided without a parent's/guardian's consent. To constitute a medical emergency, the condition must constitute a substantial or immediate threat to the life or health of the patient. Efforts should be made to locate the patient's parent/legal guardian and obtain consent prior to initiation of treatment if at all possible. Those efforts should be

documented in the medical record.

Treatment should be limited solely to the condition immediately threatening the life or health of the patient. The nature of the medical emergency should be documented in the patient's medical record including the reason that emergency treatment was instituted without parent/legal guardian consent or a court order.

B. Divorced Parents/Separated Parents

Generally, divorced parents have the legal authority to consent for their child's health care unless the parent does not have legal custody of that child. If there is any question or dispute about whether a divorced parent has the legal authority to consent for medical care, contact Social Work and ultimately the Risk Management Department for assistance. Children's may require the disputing parent to provide the court order for custody.

C. Married Minor

A minor between the ages of 16 and 18 who is married is considered emancipated and can consent for his/her medical treatment.

D. Minor Parents

Minor parents may consent to treatment for their child.

E. Patients in Custody of Law Enforcement or Emergency Detention

When a patient is in custody of a law enforcement agency, in general, the patient/parent/legal guardian retains their right to consent and/or refuse treatment. See Administrative Policy and Procedure: Incarcerated Patients or Patients in Police Custody.

F. Foster Care

1. In general, the parent/legal guardian(s) retain the right to consent for care.
2. Foster parents generally cannot consent for care.
3. If the parent cannot be reached, the Child Protective Service agency may be able to consent for outpatient/routine care if they were granted legal custody of the child.
4. Consent for hospitalization and treatment, surgery, sedation, or other invasive or specialty treatment generally must be obtained from the parent/legal guardian.

G. HIV Testing

If the patient is 14 years of age or older, the patient must consent for HIV testing. If the patient is under 14 years of age, the parent/legal guardian must consent for HIV testing; See Patient Care Policy and Procedure: HIV Testing and Disclosure of Results.

H. Sexually Transmitted Diseases

A physician may treat a minor infected with a sexually transmitted disease or examine and diagnose a minor for the presence of such a disease without obtaining the consent of the minor's parent/legal guardian.

I. Implied Consent Law

See Patient Care Policy and Procedure: Police Requests for Alcohol and Drug Testing of Blood and Urine Specimens.

J. Minors Placed for Adoption

When a minor has been placed for adoption, but the adoption is not final, the court, state, or private agency should be contacted in order to determine who has the authority to consent to needed medical treatment.

K. Surrogacy

The surrogate mother and/or spouse generally consent for care until a court orders otherwise. Consult with Social Work and Risk Management for further guidance.

Resources

Administrative Policies & Procedures:

Privacy - Use and Disclosure of Protected Health Information with and Without an Authorization
Privacy - Photographing - Videotaping and Other Recording of Patients, Clients and Caregiver
Patient Access-Confidential Guarantor
Incarcerated Patients or Patients in Police Custody Surrogate

Patient Care Policy & Procedures:

Police Requests for Alcohol and Drug Testing for Allegedly Driving Under the Influence
Refusal to Consent to Treatment or Blood Products
HIV Testing and Disclosure of Results
Abbreviations
Blood and Blood Components: Verification Procedure, Administration and Monitoring
IRB-Research: Conducting Research on Human Subjects at Children's Hospital and Health System
Language Services

Wisconsin Statutes, Chapter 48
Wisconsin Statutes, Chapter 252
Wisconsin Statutes, Chapter 54
Wisconsin Statutes, Chapter 51
Wisconsin Statutes, Chapter 767
Wisconsin Administrative Code, Med § 18
Wisconsin Administrative Code, DHS § 94.03

Approved by the:
Joint Clinical Practice Council June 17, 2024
Milwaukee Medical Executive Committee August 5, 2024
Fox Valley Medical Executive Committee August 7, 2024
Surgicenter Medical Executive Committee August 22, 2024

Appendix A: Table of Who Can Provide Consent

Special Situation:	Who can Consent:
Adoption – Pre-Adoption	Contact Social Work. Generally, the Parent or legal guardian
Adoption – Post-Adoption	Adoptive Parent(s)
Divorced Parents/Parents have Joint Custody	Either parent
Divorced Parents/one parent has sole legal custody	The parent with court order for sole legal custody
Emancipated Minor – Married	Minor patient
Emergency Detention/Minors in Law Enforcement Custody	Parent/legal guardian
Emergency Treatment	No consent needed but should try to locate the parents for consent
HIV Testing – patient 14 years of age or older	Patient
HIV Testing – patient under 14 years of age	Parent/legal guardian
Parents	Either parent
Mental and Behavioral Health or Psychiatric Treatment – Patient 14 years of age or older	Patient and parent/legal guardian
Mental and Behavioral Health or Psychiatric Treatment – Patient under 14 years of age	Parent/legal guardian
Police Request for Collection and Testing of Specimens	See P&P: Police Requests for Alcohol and Drug Testing for Allegedly Driving Under the Influence
Reproductive Decisions – diagnosis of pregnancy and prescribing contraceptives	Patient or parent/legal guardian If patient requests confidential services may advise patient of confidential resources outside of Children's Wisconsin for service.
Sexually Transmitted Diseases	Patient or parent/legal guardian Patient must be informed that a bill will go to his/her parent. If patient requests confidential services, may advise patient of confidential resources outside of Children's Wisconsin for service.
Foster Care or Court Ordered Placement in Group Home or Other Facility – Legal Custody has been transferred to the state or county.	Parent/legal guardian. The Child Protective Services agency could be contacted to get the appropriate signatures depending on custody & guardianship.

Appendix B: Consent for Treatment (single encounter) form

Children's Wisconsin

PATIENT LABEL HERE

Consent for Treatment
(single encounter)

Please read this form. Ask questions if you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc. ("Children's") employees, doctors, and other healthcare providers to evaluate and treat my child.
- Treatment may include physical exams, x-rays, labs, giving or prescribing medicine, ordering or performing tests and procedures, and other care as needed.
- I have the right to talk about options for my child's care. I will have a chance to ask questions.
- Children's may test or properly dispose of any samples or tissues taken from my child's body.
- I understand my child may go home or to another facility before all medical problems are known or treated. I understand that I may need to make appointments for follow-up care.
- Doctors and specialists who care for my child may not be employees of Children's. Children's is not responsible for their actions.
- Children's is a teaching organization. Students may be involved in my child's care.
- Services may be offered via telehealth. I understand that I am responsible for security of my technology. I also understand that not all conditions are able to be diagnosed through telehealth and I may need an office visit. Finally, if the service is interrupted for any reason, and I am having an emergency, I will not call my provider back but will either call 9-1-1 or go to my closest emergency department.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children's locations and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's locations and on childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos, videos, or recordings of other patients or of staff caring for my child.
- My child's medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my personal items.

Financial Agreement

- I agree to pay for all charges that are due because of care and treatment at Children's Hospital and Health System, Inc. (called "Facility") and by any other provider.
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.

C8050N (08/24)

DT104

Financial Agreement

- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me by providers other than Facility.
- If my account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I do not pay my medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's and its contractors may call, email, or text me for any purpose including appointments, treatment, billing, collections, and surveys.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me.

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above.

Signature: X _____
Patient, Parent or Legal Guardian

Relationship to Patient: _____

Date: _____ **Time:** _____

Verbal Consent: ☐ **Yes** _____
Relationship to Patient

_____
CHHS Witness to the Signature

_____
Second CHHS Witness (Only for Verbal Consent)

Appendix C: Outpatient Consent for Treatment (annual) form

Children's Wisconsin

PATIENT LABEL HERE

Outpatient Consent for Treatment
Primary Care, Specialty Care and Ancillary Services

Please read this form. Ask questions if you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc. ("Children's) employees, doctors, and other healthcare providers to evaluate and treat my child.
- Treatment may include physical exams, x-rays, labs, giving or prescribing medicine, ordering or performing tests and procedures, and other care as needed.
- I have the right to talk about options for my child's care. I will have a chance to ask questions.
- Children's may test or properly dispose of any samples or tissues taken from my child's body.
- I understand my child may go home or to another facility before all medical problems are known or treated. I understand that I may need to make appointments for follow-up care.
- Doctors and specialists who care for my child may not be employees of Children's. Children's is not responsible for their actions.
- Children's is a teaching organization. Students may be involved in my child's care.
- Services may be offered via telehealth. I understand that I am responsible for security of my technology. I also understand that not all conditions are able to be diagnosed through telehealth and I may need an office visit. Finally, if the service is interrupted for any reason, and I am having an emergency, I will not call my provider back but will either call 9-1-1 or go to my closest emergency department.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children's locations and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's locations and on childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos, videos, or recordings of other patients or of staff caring for my child.
- My child's medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my personal items.

Financial Agreement

- I agree to pay for all charges that are due because of care and treatment at Children's Hospital and Health System, Inc. (called "Facility") and by any other provider.
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.

C1654N (06/24)

DT104

Financial Agreement

- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me by providers other than Facility.
- If my account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I do not pay my medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's and its contractors may call, email or text me for any purpose including appointments, treatment, billing, collections, and surveys.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me.

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above. This consent form is good for one year.

Signature: X _____ **Relationship to Patient:** _____
Patient, Parent or Legal Guardian

Date: _____ **Time:** _____ **Verbal Consent:** ☐ **Yes** _____
Relationship to Patient

_____
CHHS Witness to the Signature

_____
Second CHHS Witness (Only for Verbal Consent)

Appendix D: Consent by Minor for Reproductive Health Services form

Children's Wisconsin

PATIENT LABEL HERE

Consent by Minor for Reproductive Health Services

Please read this form. Ask questions if you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc. ("Children's") employees, doctors, and other healthcare providers to evaluate and treat me.
- Reproductive health services may include contraceptive care, sexually transmitted disease testing and treatment, HIV testing, pregnancy testing and other similar services.
- I have the right to talk about options for my care. I will have a chance to ask questions.
- Children's may test or properly dispose of any samples or tissues taken from my body.
- I understand I may go home or to another facility before all medical problems are known or treated. I understand that I may need to make appointments for follow-up care.
- Doctors and specialists who care for me may not be employees of Children's. Children's is not responsible for their actions.
- Children's is a teaching organization. Students may be involved in my care.

Services may be offered via telehealth. I understand that I am responsible for security of my technology. I also understand that not all conditions are able to be diagnosed through telehealth and I may need an office visit. Finally, if the service is interrupted for any reason, and I am having an emergency, I will not call my provider back but will either call 9-1-1 or go to my closest emergency department.

Patient Rights and Privacy

- I have rights as a patient. Rights and Responsibilities information is posted at Children's locations and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's and on childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos, videos, or recordings of other patients or of staff caring for me.
- My medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my personal items.

Financial Agreement

- I agree to pay for all charges that are due because of care and treatment at Children's Hospital and Health System, Inc. (called "Facility") and by any other provider.
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.

C8049N (06/24)

DT758

Financial Agreement

- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me by providers other than Facility.
- If my account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I do not pay my medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's and its contractors may call, email or text me for any purpose including appointments, treatment, billing, collections, and surveys.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's, and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me.

I have read this information. I am legally able to consent for myself. By signing this form, I give my permission for treatment and agree to the terms listed above. I understand that Children's cannot guarantee complete confidentiality of these services provided to me.

Signature: X_____ **Date:**_____ **Time:** _____

_____
CHHS Witness to the Signature

Appendix E: Consent for Procedure (Without anesthesia services) form

Children's Wisconsin

PATIENT LABEL HERE

Consent for Procedure
(Without anesthesia services)

Please read this form. Ask questions about anything you do not understand before you sign.

1. Name of Patient: _____

   Medical name of procedure(s): _____

   _____

   _____

   Performed by _____ and assistants.

2. I understand and have had my questions answered about:
   - The nature of the condition.
   - What is being done and why it is needed.
   - The risk of having it done.
   - The benefits of having it done.
   - The expected results.
   - Other treatment options

3. I understand that other assistants may help the doctor with certain tasks for the procedure. Assistants may include physicians, residents, fellows, physician assistants, nurse practitioners, technicians, students or other staff. They will be working under the supervision of the responsible doctor. Observers may be allowed to watch the procedure.

4. I understand that other medical problems may occur or be found during the procedure. I agree that the doctor should use his or her judgment to treat these problems which may include more procedures.

5. I am aware that there are no guarantees about the results. Medicine and surgery are not exact sciences.

6. Children's Hospital and Health Systems, Inc. ("Children's") may store, test, study and properly dispose of any removed samples or tissues.

7. Photographs and recordings may be taken by Children's for care, training, education and security purposes.

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. By signing this form I give my permission for the procedure and agree to the terms listed above.

Signature: X _____ **Relationship to Patient:** _____
Patient, Parent or Legal Guardian

Date:_____ **Time:**_____ **Phone Consent by:** _____/_____/_____
Name / Relationship to Patient / Phone number

_____ _____
Healthcare Team Witness to the Signature Date/Time

_____ _____
Second Healthcare Team Witness to Phone Consent Date/Time

C7967N (06/24)

DT648

Appendix F: Consent for Surgery/Procedure Consent (With anesthesia services & blood) form

Children's Wisconsin

PATIENT LABEL HERE

Consent for Surgery/Procedure
(With anesthesia services & blood)

Please read this form. Ask questions about anything you do not understand before you sign.

1. Name of Patient: _____

   Medical name of surgery/procedure: _____

   _____

   _____

   Performed by: _____ and assistants.

2. I understand and have had my questions answered about:
   - The nature of the condition.
   - What is being done and why it is needed.
   - The risk of having it done.
   - The benefits of having it done.
   - The expected results.
   - Other treatment options.

3. I understand that other assistants may help the doctor with certain tasks for the surgery/procedure or anesthesia. Assistants may include physicians, residents, fellows, physician assistants, nurse practitioners, technicians, students, or other staff. They will be working under the supervision of the responsible doctor. Observers may be allowed to watch the surgery/procedure.

4. I understand that other medical problems may occur or be found during the surgery/procedure. I agree that the doctor should use his or her judgment to treat these problems. This may include more surgeries or procedures.

5. I agree to anesthesia care under the direction of a medical staff anesthesiologist.

6. I agree to the use of blood, blood products or both. The doctor will decide if it is needed. I understand that there are risks such as fever, chills, itching and hives. I know that the blood bank takes many safety steps to match the blood and screen it for infections such as HIV and hepatitis. I understand the risks of refusing blood. The benefits may be to stop bleeding, raise oxygen levels and improve blood pressure to prevent death.

If applicable, please check one of the boxes below.

☐ Blood has been donated before surgery.

☐ **I refuse blood or blood products.***

*** Competent adult patients may refuse blood or blood products. For minor patients, please refer to the Refusal to Consent to Treatment or Blood Products Policy and Procedure.**

7. I understand that all surgical/procedural care, including the use of anesthesia and blood or blood products, has risks. These risks have been explained to me. Risks may include corneal abrasions, broken teeth, blood loss, infection, injury to structures near the surgery area, permanent disability, cardiac arrest and death, and other unknown risks. I am aware that there are no guarantees about the results. Medicine and surgery are not exact sciences.

8. Children's Hospital and Health System, Inc. ("Children's") may store, test, study and properly dispose of any samples, organs, tissues or body parts.

9. Photographs and recordings may be taken by Children's for care, training, education and security purposes.

C1400IN (06/24)

DT101

Children's Wisconsin

PATIENT LABEL HERE

Consent for Surgery/Procedure
(With anesthesia services & blood consent)

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to sign for my child. By signing this form, I give my permission for the surgery/procedure and agree to the terms listed above.

Signature: X_____ **Relationship to patient:** _____
Patient, Parent or Legal Guardian

Date:_____ **Time:**_____ **Phone Consent by:**_____ / _____ / _____
Name Relationship to Patient Phone Number

_____ _____ _____ _____
Healthcare Team Witness to the Signature Date/Time Second Healthcare Team Witness to Phone Consent Date/Time

Picture for Surgery/Procedure (optional)

C1400N (06/24)

Appendix G – School Health Consents for Treatment (“excluding medications”) and School Health Consent for Medication and/or Aromatherapy (“essential oils”)

Children's Wisconsin

Consent for Treatment ("excluding medications")
Community Health School Nurse

Please read this form. Ask your school nurse questions if you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc. ("Children's") employees, doctors, and other healthcare providers such as school nurses, nurse practitioners, and respiratory therapists (“Children’s staff”) to evaluate and treat my child at school during school hours or school-sponsored activities.
- Treatment may include, but is not limited to, physical examinations or assessments, screenings, treatment of illness or injury, and other care as needed.
- Children’s staff may not resolve my child’s medical problems during school hours. I may need to make appointments for follow up care.
- Children’s is a teaching organization. Students may be involved in my child’s care.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children’s locations and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children’s locations and at childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- I cannot take photos, videos, or recordings of other patients or of Children’s staff caring for my child.
- My child’s medical records may be shared with health providers and Children’s. This is for treatment and health care operations.
- My child’s health information will be documented in their student record and may be documented in the Children’s medical record.
- Children’s is not responsible for my child’s personal items left in the health office.

Financial

- There are no fees for services provided to my child by Children's staff while at school during school hours or school-sponsored activities.

Communication

- Children’s, and its contractors may call, email, or text me for any purpose including appointments, treatment, billing, collections, and surveys. Staff may need to call, email or text me.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children’s and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me.

I have read this information. By signing this form, I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. My consent is valid for the duration of my child's enrollment in the Milwaukee Public School system. I may revoke my consent in writing with Children's staff at any time.

Child's Name:_____ Child's Date of Birth: _____

Signature: X_____ Date: _____
Parent or Legal Guardian

Relationship to Child: _____

C8022N/NS (06/24) DT289

Children's Wisconsin

Consent for Medication and/or Aromatherapy (essential oils)
Community Health School Nurse

Please read this form. Ask your school nurse questions if you do not understand before you sign.
This consent form must be completed every school year.

Treatment

- I authorize Children's Hospital and Health System, Inc. ("Children's") employees, doctors, and other healthcare providers such as school nurses, nurse practitioners, and respiratory therapists ("Children's staff") to provide medication and/or aromatherapy (essential oils) to my child in select Milwaukee Public Schools for temporary relief of pain or asthma related symptoms.
- The use of each medication is indicated in Children's patient care protocols, approved by a Children's Medical Director, and are available on a limited basis.
- Aromatherapy (essential oils) may be used as an alternative to medication. This may improve comfort, and reduce stress and anxiety.
- Children's staff may only provide medications and/or aromatherapy (essential oils) with the written consent of a parent/legal guardian and cannot take consent over the telephone.
- Only Children's staff may administer medications and/or aromatherapy (essential oils). Children's staff must be present in the school to administer medication and/or aromatherapy (essential oils).
- Any leftover medications that are not picked up by the parent/legal guardian (or adult designee) by the end of the school year will be properly discarded by Children's staff.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children's locations and at Children's locations and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's locations and at childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- I cannot take photos, videos, or recordings of other patients or of Children's staff caring for my child.
- My child's medical records may be shared with health providers and Children's. This is for treatment and health care operations.
- My child's health information will be documented in their student record and may be documented in the Children's medical record.
- Children's is not responsible for my child's personal items.

Financial

- There are no fees for services provided to my child by Children's staff while at school during school hours or school-sponsored activities.

Communication

- Children's and its contractors may call, email, or text me for any purpose including appointments, treatment, billing, collections, surveys, and/or prior to providing medications and/or aromatherapy (essential oils) to my child.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's and its contractors, permission to contact me at any of the current or future phone numbers and email addresses that I provide and know it may result in phone or data charges to me.

C8061N/NS (06/24) DT289

My child has allergies to the following medication(s):_____

If Children's Wisconsin protocol or policy criteria are met, I authorize Children's staff to give my child:

Check all that apply:

☐ Acetaminophen (Tylenol®) ☐ Ibuprofen (Advil®) ☐ Aromatherapy (essential oils); Lavender or Bergamot

☐ Albuterol (Proventil®); child *MUST* have a current prescription for a rescue inhaler to receive this medication at school

I have read this information. By signing this form, I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. My consent is valid until September 30th of the following school year. I may revoke my consent in writing with Children's staff at any time.

Child's Name:_____ Child's Date of Birth: _____

Signature: X _____ Date:_____

Parent or Legal Guardian

Relationship to Child: _____

Appendix H – Surgicenter of Greater Milwaukee ("Surgicenter") Consent for Treatment

Children's Wisconsin

Consent for Treatment

PATIENT LABEL HERE

Surgicenter of Greater Milwaukee LLC

Please read this form. Ask questions about anything you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc. / Surgicenter of Greater Milwaukee LLC ("Children's") employees, doctors, and other healthcare providers to evaluate and treat my child.
- Treatment may include all routine ambulatory surgery services, physical examinations, x-rays, labs, administering or prescribing medications, ordering or performing other tests or procedures, and other care as needed.
- I have the right to talk about options for my child's care. I will have a chance to ask questions.
- Children's may test or properly dispose of any samples of tissues taken from my child's body.
- I understand my child may go home or go to another facility before all medical problems are known or treated. I understand that I may need to make appointments for follow-up care.
- Doctors and specialists who care for my child may not be employees of Children's. Children's is not responsible for their actions.
- Children's is a teaching organization. Students may be involved in my child's care.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children's locations and at childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's locations and on childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos, videos, or recordings of other patients or of staff caring for my child.
- My child's medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my personal items.

Financial Agreement

- I agree to pay for all charges that are due because of care and treatment at Children's Hospital and Health System, Inc. (called "Facility") and by any other provider.
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.

C8009N (06/24)

DT104

Financial Agreement

- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me by providers other than Facility.
- If my account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I do not pay my medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's and its contractors may call, email or text me for any purpose including appointments, treatment, billing, collections, and surveys.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me.

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above.

Signature: X_____
Patient, Parent or Legal Guardian

Relationship to Patient: _____

Date: _____ **Time:** _____

Verbal Consent: ☐ **Yes** _____
Relationship to Patient

_____
CHHS Witness to the Signature

_____
Second CHHS Witness to Verbal Consent

Appendix I – Outpatient Mental and Behavioral Health Consent for Treatment

Children's Wisconsin

Consent for Outpatient Mental and Behavioral Health Treatment

Please read this form. Ask questions if you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc. ("Children's") employees, doctors, and other health care providers to evaluate and treat me and/or my child.
- I have the right to talk about options for my (or my child's) care. I will have a chance to ask questions.
- Doctors and specialists who care for my child may not be employees of Children's. Children's is not responsible for their actions.
- Children's is a teaching organization. Students may be involved in my child's care.
- Treatment may include safety evaluations, brief therapy and/or consultation, immediate interventions, and other care as needed. To help understand the treatment, I will get information about the following:
  - The outpatient mental and behavioral health treatment that will be offered to me/my child under the treatment plan.
  - Treatment recommendations and benefits of the treatment recommendations.
  - Possible outcomes and side effects for treatment recommended in the treatment plan.
  - Approximate duration and desired outcome of treatment recommended in the treatment plan.
  - Treatment alternatives.
  - The fees that you or a responsible party may be expected to pay for the proposed services. This can be found on childrenswi.org.
  - The rights of you and your child receiving outpatient mental and behavioral health services, including you/your child's rights and responsibilities in the development and implementation of an individual treatment plan.
- Services may be offered via telehealth. I understand that I am responsible for security of my technology. I also understand that not all conditions are able to be diagnosed through telehealth and I may need an office visit. Finally, if the service is interrupted for any reason, and I am having an emergency, I will not call my provider back but will either call 9-1-1 or go to my closest emergency department.

Discharge

- I understand that care may be finished in the clinic and I or my child may be discharged if:
  - Treatment is finished or I ask to stop care.
  - I miss visits, do not call the provider, or fail to return a call after missing a significant amount of care.
  - I am referred to another agency for different care.
  - I do not follow the recommended care or cause issues in the clinic that are disruptive.

Emergencies

- For non-life threatening emergencies, during business hours you may call the office and ask to speak with your provider. If they are not available, you may be connected with another therapist or the clinic manager.
- For non-life threatening emergencies, during non-business hours, you will be directed to an answering service to assist you.
- When applicable, you or your parent/legal guardian may need to refer to the individual emergency management plan developed between you and your provider. The provider reserves the right to contact an identified patient support person and/or call local emergency management services in the event of an emergency. Please discuss this further with your provider.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children's locations and on childrenswi.org. I may ask for a copy.
- I have rights to privacy. Privacy Practices are posted at Children's locations and on childrenswi.org. I may ask for a copy. I have reviewed a copy or decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos, videos, or recordings of other patients or staff caring for me (and/or my child).
- My (and/or my child's) medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my (and/or my child's) personal items.

C1244N (06/24)

DT636

Financial Agreement

- I agree to pay for all charges that are due because of care and treatment at Children's Hospital and Health System, Inc. (called "Facility") and by any other provider.
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.
- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me by providers other than Facility.
- If my account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I do not pay my medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's and its contractors may call, email, or text me for any purpose including appointments, treatment, billing, collections, and surveys.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for me or my child. By signing this form, I give my permission for treatment and agree to the terms listed above. This consent is good for one year.

Signature: X _____ **Relationship to Patient:**_____
Patient, Parent or Legal Guardian

Date: _____ **Time:** _____

Signature of patient/client age 14 years and older: X _____ **Date:** _____ **Time:** _____

Witness to the Signature: X_____ **Date:** _____ **Time:** _____

Appendix J – Mental and Behavioral Health (single encounter) Consent for Treatment

Children's Wisconsin

Mental and Behavioral Health
Consent for Treatment (single encounter)

Please read this form. Ask questions if you do not understand before you sign.

Treatment

- I authorize Children's Hospital and Health System, Inc., ("Children's") employees, doctors, and other health care providers to evaluate and treat me (or my child).
- Treatment may include, but is not limited to, safety evaluations, brief therapy and/or consultation, immediate interventions, and other care as needed.
- I have the right to talk about options for my (or my child's) care. I will have a chance to ask questions.
- I understand I (or my child) may go home or to another facility before all problems are known or treated. I understand that I may need to make appointments for follow-up care.
- Doctor's and specialists who care for me (or my child) may not be employees of Children's. Children's is not responsible for their actions.
- Children's is a teaching organization. Students may be involved in my (or my child's) care.
- Services may be offered via telehealth. I understand that I am responsible for security of my technology. I also understand that not all conditions are able to be diagnosed through telehealth and I may need an office visit. Finally, if the service is interrupted for any reason, and I am having an emergency, I will not call my provider back but will either call 9-1-1 or go to my closest emergency department.

Emergencies

For emergencies I may do the following:

- Call 9-1-1 or go to my nearest emergency department.
- Call or text the Suicide and Crisis Life line at 9-8-8.
- If applicable, refer to my safety plan as discussed at my visit.

Patient Rights and Privacy

- I have rights as a patient and family. Rights and Responsibilities information is posted at Children's locations and on childrenswi.org. I may ask for a copy.
- I have the right to privacy. Privacy Practices are posted at Children's locations and on childrenswi.org. I may ask for a copy. I have reviewed a copy or have decided not to review the privacy information.
- Photos and recordings may be taken by Children's for care, training, education or security purposes.
- I cannot take photos, videos, or recordings of other patients or of staff caring for me (and/or my child).
- My (and/or my child's) medical records may be shared with health providers, insurance companies and Children's. This is for treatment, payment and health care operations.
- Children's is not responsible for my (and/or my child's) personal items.

Financial Agreement

- I agree to pay for all charges that are due because of care and treatment at Children's Hospital and Health System, Inc. (called "Facility") and by any other provider.
- I understand that care and treatment may require labs or other tests that are under the supervision of an independent provider who may bill separately.
- I understand and authorize Facility to file any paper work on my behalf to obtain payment to cover health care costs incurred by me, including any right of the provider to appeal an adverse decision by a payer.
- I hereby irrevocably assign and transfer to Facility and the providers and professionals associated with Facility, for application to my bill for services, all of my rights, benefits, and claims (including but not limited to those arising under ERISA) for reimbursement under any federal or state healthcare plan or program (including not limited to Medicare and Medicaid), insurance policy, managed care arrangement, self-funded or other benefit plan, or other similar third party arrangement that covers health care costs for which payment may be available to cover the cost of the services provided (collectively, "My Coverage"). This specifically includes filing administrative and other appeals and arbitration/litigation in Facility's name on my behalf, and I authorize Facility to retain an attorney of Facility's choice on my behalf for collection of Facility's bills.

C8064N (06/24) DT636

Financial Agreement

- I may have member appeal rights. I understand that I am responsible for all member appeals.
- I understand that if I choose to have My Coverage billed, it is my responsibility to ensure that the rendered service or services are covered by My Coverage.
- I understand that it is possible My Coverage will not pay for the services. Reasons which My Coverage may give for not paying for services include, but are not necessarily limited to: non-coverage, medical necessity, no authorization, services that are deemed experimental, and otherwise based on the limits of My Coverage. I understand that if My Coverage refuses to pay for the services, regardless of the reason My Coverage gives for that refusal, I will be responsible for payment of these services.
- Notwithstanding the above, I reserve and retain any and all rights under My Coverage (including but not limited to those arising under ERISA) related to services provided to me/my child by providers other than Facility.
- If my/my child's account becomes delinquent, I understand that, if and as permitted by applicable federal and state law, Facility may access my credit file, place my account with a collection agency for further collection activity (including access to my credit file), and may assess interest to my account. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts.
- A photocopy of this assignment shall be considered effective and valid as the original.

What this means

- I understand that care and treatment may include labs and tests ordered by a provider that is not employed by Facility.
- The Facility will send their own bills. I agree that all insurance payments will be paid to Facility and to the providers. What I pay depends on my insurance. I am responsible for charges not covered by insurance.
- I give permission to Facility to bill my insurance. I need to check with my insurance to make sure that the care and tests are covered.
- If I do not pay my/my child's medical bill, Facility may take action for payment. Facility may access my credit, send my account to a collection agency and may charge me interest.

Communication

- Children's and its contractors may call, email, or text me for any purpose including appointments, treatment, billing, collections, and surveys.
- Prerecorded messages and auto-dialers may be used to contact me.
- I give Children's and its contractors, permission to contact me at any of the current or future telephone numbers and email addresses that I provide and know it may result in phone or data charges to me.

I have read this information. I hereby give my informed consent for services under the terms stated above. I am legally able to consent for myself (or my child). By signing this form, I give my permission for treatment and agree to the terms listed above.

Signature: X_____**Relationship to Patient:** _____ **Date:**_____**Time:**_____
Patient, Parent or Legal Guardian

Signature of patient/client age 14 years and older: X_____**Date:**_____**Time:**_____

Children's Witness to the Signature: X_____**Date:**_____**Time:**_____

Verbal Consent: ☐ **Yes**_____**Second Children's Witness (Only for Verbal Consent):** _____
Relationship to Patient

*Parent/legal guardian notified that written consent is required. Copy of consent form sent to parent/legal guardian via:
☐ Home with patient ☐ MyChart ☐ Email ☐ Other: _____

Appendix K – Chiropractic Consent for Treatment

Children's Wisconsin

Chiropractic Treatment Agreement

Before your child has chiropractic treatment, it is important to understand this type of care, as well as the risks.

Please read this agreement and ask questions if you do not understand. Sign at the very end.

What is Chiropractic Treatment?
It is the way doctors treat pain and stiffness. Some ways include:

- Soft tissue work. This massages the muscles.
- Stretches. These help lengthen tight muscles.
- Back (spinal or peripheral joint) work or manipulation.
  - This is a controlled pressure to your joint.
  - It may move the joint past its normal range of motion.
  - It can cause a popping or clicking sound.
- Exercises.

How can Chiropractic Treatment help?
This treatment can help with better motion and use in the problem area because of less muscle and joint pain and stiffness. It can help your progress with exercise and other treatments.

What are the risks of Chiropractic Treatment?
These types of treatments and exercise are generally safe and handled well by the body. However, possible risk and side effects include:

- Soreness after treatment for a short time
- Headaches, muscle stiffness, dizziness
- Bruises, joint or muscle sprain
- Not common/rare: spinal disc herniation, broken bones, nerve damage (including Cauda Equine Syndrome), vascular injury (including stroke), epidural spinal or intraarticular hematoma

Let your doctor know if you have ever had poor reactions with any of the type of treatment listed on this form.

What other options are there instead of Chiropractic Treatment?

- Wait and watch under your doctor's care
- Use ice or heat on the problem area
- Exercise
- Therapeutic massage
- New or other medical care visits
- Mental health care support

Consent Signature
I understand the following:

- While not likely, chiropractic treatment may have no clear effect on the condition or symptoms and changes over time.
- There are no guarantees about the results. Medicine, including chiropractic care, is not an exact science.
- Assistants may help the doctor with treatment.
  - These may be residents, fellows, physician assistants, nurse practitioners, technicians, students or other staff.
  - They will be working under the supervising doctor and may be watching treatment.

C8069N (08/23)

I have read this information. I give my informed consent for services under the terms stated above. I am legally able to consent for my child. By signing this form I give my permission for the treatment and agree to the terms listed above.

Signature: X _____ **Relationship to patient:** _____
Patient, Parent or Legal Guardian

Date: _____ **Time:** _____ **Phone Consent by:** _____ / _____ / _____
Name Relationship to Patient Phone Number

_____ _____
Healthcare Team Witness to the Signature Date/Time Second Healthcare Team Witness to Phone Consent Date/Time

APPENDIX L – Informed Consent for Testosterone

Children's Wisconsin
Kids deserve the best.

Informed Consent for Testosterone (Gender Affirming Hormone Therapy)

Please read this form. Ask questions if you do not understand before you sign.

Before using testosterone to transition and masculinize your body, you and your parent(s) or legal guardian(s) need to understand the possible advantages, disadvantages and risks associated with this medication. It's important that you understand this information before you begin taking testosterone.

Treatment

What is testosterone?
Testosterone is the sex hormone that makes certain features appear typically male. It builds muscle and causes the development of facial hair and a deeper voice. Testosterone has been used to help treat transmasculine youth for many years; however, these medications are considered "off-label" for this purpose. The term "off-label" means that the medication has not been approved as safe and effective by the US Food and Drug Administration for this specific indication of use. The medication and dose that is recommended is based on the judgment and experience of the healthcare providers and the information that is currently available in the medical literature.

How is testosterone taken?
Testosterone is usually injected every one to four weeks. It is not used as a pill because the body may not absorb it properly and it can cause potentially fatal liver problems. Some people use topical skin creams, but these can be more expensive and more difficult to apply. The type of testosterone used is a decision between you and your medical provider.

What are the benefits of Testosterone therapy?

The masculinizing effects of testosterone therapy may take several months to become noticeable and more than five (5) years to be complete.

Some of the changes will be PERMANENT, which means they will not go away even if you stop taking testosterone. The following changes are PERMANENT:

- Hair loss, especially at the temples and crown of the head, possibly male pattern baldness
- Facial hair growth (i.e., beard, mustache)
- Deepened voice
- Increased body hair growth (i.e., on arms, legs, chest, back, buttocks, abdomen, etc.)
- Enlargement of clitoris (i.e., "bottom growth")

Some of the changes are NOT PERMANENT, which means they will likely reverse if testosterone is stopped. The following changes are NOT PERMANENT:

- Redistribution of body fat to a more typical male pattern (i.e., abdominal fat may increase while fat in the breasts, buttocks, and thighs may decrease)
- Increased muscle development
- Increased red blood cells
- Increased sex drive and energy levels. Possibly increased feelings of aggression or anger
- Acne, which may become severe and may require treatment
- Cessation of menstrual cycles (periods) and suspended ovulation (maturing of ova) because testosterone therapy causes estradiol levels to decrease. The lower estradiol

1

levels can also cause changes to/thinning of vaginal tissue/lining leading to increased potential for easy damage, dryness, or yeast infections
- Protection against bone thinning (osteoporosis)

What are the risks and possible side effects of Testosterone Therapy?
- Acne (may permanently scar)
- Increased risk of developing blood clots; blood clots in the legs or arms (deep vein thrombosis or "DVT") can cause pain and swelling; blood clots to the lungs (pulmonary embolus) can interfere with breathing and getting oxygen to the body; blood clots in the arteries of the heart can cause heart attacks; blood clots in the arteries of the brain can cause a stroke; blood clots to the lungs, heart or brain can result in death.
- Emotional changes such as more aggression
- May cause or worsen headaches or migraines
- High blood pressure (hypertension)
- Increased red blood cell count
- Increased risk for heart disease
- The ovaries will produce less estrogen, and you may become infertile (unable to get pregnant); how long this takes to happen and if it becomes permanent varies greatly from person to person. Before you initiate testosterone therapy, you can choose to see a specialist to review options related to preserving fertility.
- Because the effect on fertility is hard to predict, if you have penetrative sex with someone who could get you pregnant, you or your partner should still use birth control (e.g. condoms).
- Changes in blood tests for the liver; testosterone may possibly contribute to damage of the liver from other causes.
- Hair loss, especially at the temples and crown of the head, possibly male pattern baldness
- More abdominal fat. Fat is redistributed to male body shape.
- Swelling of hands, feet, and legs
- Thinning of vaginal walls and tissue of cervix which can increase risk for damage during vaginal sex and increase risk of getting sexually transmitted infections, including HIV
- Weight gain, which can increase risk for high blood sugar (diabetes)

Warning – Who should not take Testosterone?
Testosterone should not be used by anyone who is pregnant or has uncontrolled coronary artery disease, as it could increase the risk of fatal heart attack.

Testosterone should be used with caution and only after a full discussion of risks by anyone who
- Has acne
- Has a family history of heart disease or breast cancer
- Has had a blood clot
- Has high cholesterol levels
- Has liver disease
- Has high red blood cell count
- Is obese
- Smokes cigarettes

What are the Medical Complications and On-Going Care when taking Testosterone?

The medical effects and safety of testosterone are not completely known. There may be long-term risks that are not yet known. As mentioned above, using testosterone to masculinize is an off-label use. To reduce the risk of complications, you are expected to take the medication as prescribed and have laboratory testing and clinic visits as requested by your medical provider. Please let your medical provider know if you have any questions or concerns while on treatment.

Taking too much testosterone will increase health risks. It will not make changes happen more quickly or more significantly. Too much can cause the body to convert extra testosterone into estradiol which can slow down or stop masculine appearance. No one knows if this could increase the risk of cancers of the breast, the ovaries, or the uterus.

Periodic blood tests will be required to check for therapeutic (goal) testosterone levels as well as to monitor for complications.

Regular preventive health care exams including breast exams and mammograms at appropriate age, should be continued. As long as you have female internal organs you will need gynecologic health exams.

Taking testosterone and the process of transitioning can affect mood. While some transgender men are relieved and happy with the changes that occur, it is important that you are under the care of a mental and behavioral health therapist while undergoing transition. The therapist can work with you, your family and friends and your school staff.

What are my responsibilities for the ongoing treatment of my child if testosterone is prescribed?

- To support your child in using testosterone for gender affirming treatment as prescribed, you agree to tell your child's health care provider if your child has any problems or side effects or is unhappy with the medication.
- You or your child can choose to stop taking this medication at any time. You know that if you or your child decides to stop testosterone therapy, you need to make a safe plan to stop the medications with the help of your child's health care provider.
- During treatment, your child should be working regularly with a mental health provider knowledgeable in gender incongruence.

You agree to the following:

- Schedule and bring your child to required check-ups to make sure that they are responding as expected to the medication.
- Tell your child's provider about any other medications, vitamins, supplements or other substances that your child uses.
- Tell your child's provider and make a safe plan to stop medications if your child decides that they want to stop testosterone.
- Discuss any questions and concerns about: testosterone treatment; adjustment concerns related to your child's social environment and their gender affirmation process; and/or changes in your child's family, school, or social systems of support, either positive or negative.
- Ensure that your child maintains a therapeutic relationship with a mental health provider.

Children's Wisconsin
Kids deserve the best.

Provider Signature _____ Date _____

Second Witness for telephone or telemedicine consent:

Signature _____ Date _____

Patient Assent

My signature below confirms that:

- I want to begin taking masculinizing medications (testosterone).
- I agree to take the testosterone as prescribed. I will not purchase testosterone or any other forms of testosterone or other hormones without my physician's knowledge, and I will tell my healthcare providers if I have any problems or am unhappy with the treatment.
- I assent to taking testosterone for gender affirming therapy and agree to comply with the recommendations of my health care provider.

Patient Legal Name (printed) _____

Patient Legal Signature _____ Date _____

Division of Endocrinology 4/2023

APPENDIX M – Informed Consent for Estradiol

Children's Wisconsin

Kids deserve the best.

Informed Consent for Estradiol (Gender Affirming Hormone Therapy)

Please read this form. Ask questions if you do not understand before you sign.

Before using medications to transition and feminize your body, you and your parent(s) or legal guardian(s) need to know the possible advantages, disadvantages and risks associated with these medications. It's important that you and your parent or legal guardian's understand this information before you begin taking estradiol.

Treatment

What is Estradiol?
Estradiol is the sex hormone that makes certain features appear typically female. Estradiol has been used to help treat transfeminine youth for many years; however, these medications are considered "off-label" for this purpose. The term "off-label" means that the medication has not been approved as safe and effective by the US Food and Drug Administration for this specific indication of use. The medication and dose that is recommended is based on the judgment and experience of the healthcare providers and the information that is currently available in the medical literature.

How is Estradiol taken?
Different forms of the hormone estradiol are used to feminize appearance in transgender females. Estradiol can be given as an injection every one to two weeks, as a pill taken daily or twice a day, or as a patch applied to the skin one to two times a week.

What are the benefits of Estradiol therapy?
Estradiol therapy produces feminine changes in the body, which may take several months to become noticeable and usually take up to 3 to 5 years to be complete.

Some of the changes will be PERMANENT, which means they will not go away, even if you decide to stop taking estradiol. The following changes are PERMANENT:

- Breast growth and development. Breast size varies in all women; breasts can also look smaller if you have a broader chest.
- The testicles will get smaller and softer.
- The testicles will produce less sperm, and you will become infertile (unable to get someone pregnant); how long this takes to happen and become permanent varies greatly from person to person.

Some of the changes are NOT PERMANENT, which means the changes will likely reverse if estradiol is stopped. The following changes are NOT PERMANENT:

- Loss of muscle mass and decreased strength, particularly in the upper body.
- Weight gain. If you gain weight, this fat will tend to go to the buttocks, hips and thighs, rather than the abdomen and mid-section, making the body look more feminine.
- Skin will become softer and acne may decrease.
- Facial and body hair will get softer and lighter and grow more slowly; usually, this effect is not sufficient, and you may choose to have other treatments (electrolysis or laser therapy) to remove unwanted hair.

1

- Male pattern baldness of the scalp may slow down or stop, but hair will generally not regrow.
- Reduced sex drive.
- Decreased strength of erections or inability to get an erection. The ejaculate will become thinner and watery and there will be less of it.
- Changes in mood or thinking may occur; you may find that you have increased emotional reactions to things. Some people find that their mental health improves after starting estradiol therapy. The effects of estradiol on the brain are not fully understood.
- Estradiol will not change the bone structure of the face or body; your Adam's apple will not shrink; the pitch of your voice will not change. If necessary, other treatments may be available to help with these things.

What are the risks and possible side effects of Estradiol Therapy?

- Permanent loss of fertility (unable to get someone pregnant). Even after stopping hormone therapy, the ability to make healthy sperm may not come back. How long this takes to become permanent is difficult to predict. You can choose to bank some of your sperm before starting hormone therapy.
- Because the effect on sperm production is hard to predict, if you have penetrative sex with someone who could become pregnant, you or your partner should still use birth control (e.g. condoms).
- Increased risk of developing blood clots; blood clots in the legs or arms (deep vein thrombosis or "DVT") can cause pain and swelling; blood clots to the lungs (pulmonary embolus) can interfere with breathing and getting oxygen to the body; blood clots in the arteries of the heart can cause heart attacks; blood clots in the arteries of the brain can cause a stroke; blood clots to the lungs, heart or brain can result in death.
- Increased risk of having cardiovascular disease, a heart attack or stroke. This risk may be higher if you smoke cigarettes, are over 45 years of age, or if you have high blood pressure, high cholesterol, diabetes, or a family history of cardiovascular disease.
- Possible increase in blood pressure (hypertension); this might require medication for treatment.
- Increased risk of developing high blood sugar (diabetes).
- May cause nausea and vomiting especially when starting estradiol therapy.
- Increased risk of gallbladder disease and gallstones.
- Changes in blood tests for the liver; estradiol may possibly contribute to damage of the liver from other causes.
- May cause or worsen headaches and migraines.
- May cause elevated levels of prolactin (a hormone made by the pituitary gland); In rare occasions, individuals on estradiol for hormone therapy have developed prolactinomas, a benign tumor of the pituitary gland that can cause headaches, problems with vision, and a milky discharge from the nipples. Your medical provider will monitor your prolactin levels over time.
- May worsen depression or cause mood swings.
- May increase the risk of breast cancer. The risk is likely higher than in biologic males but lower than in biologic females; the risk is related to how long you take estradiol

Children's Wisconsin
Kids deserve the best.

therapy.

Warning –Who should not take Estradiol?
Estradiol should not be used by anyone who has a history of an estradiol-dependent cancer, or a disorder that makes them more likely to get blood clots that could travel to the lungs (unless they are also taking blood thinners and are followed by a specialist).

Estradiol should be used with caution and only after a full discussion of risks by anyone who:

- Has a strong family history of breast cancer or other cancers that grow more quickly when estradiol is present
- Has uncontrolled diabetes
- Has heart disease
- Has chronic hepatitis or other liver disease
- Has uncontrolled high cholesterol
- Has migraines or seizures
- Is obese
- Smokes cigarettes

What Are the Medical Complications and On-Going Care When Taking Estradiol?
The medical effects and safety of estradiol are not completely known. There may be long-term risks that are not yet known. As mentioned above, using estradiol to feminize is an off-label use. To reduce the risk of complications, you are expected to take the medication as prescribed and have laboratory testing and clinic visits as requested by your medical provider. Please let your medical provider know if you have any questions or concerns while on treatment.

Taking too much estradiol will increase health risks. It will not make changes happen more quickly or more significantly. No one knows if this could increase the risk of cancers of the breast.

Periodic blood tests will be required to check for therapeutic (goal) estradiol and testosterone levels as well as to monitor for complications.

Regular preventive health care exams should be continued, including breast exams and mammograms at appropriate ages. As long as you have male organs you will need testicle and prostate health exams.

Estradiol should be stopped two weeks before any surgery or when immobile for a long time (for example, if you break a leg and are in a cast). This will lower the risk of getting blood clots. It can be started again about a week after back to normal or when healthcare providers determine it is okay. Please contact your medical provider for directions on when to stop and how to resume estradiol.

If estradiol must be stopped, you may still be able to take androgen blockers (spironolactone or puberty blockers) to help prevent the effects of testicles producing testosterone again.

Taking estradiol and the process of transitioning can affect mood. While some transgender women are relieved and happy with the changes that occur, it is important that you are under the

Children's Wisconsin
Kids deserve the best.

care of a gender-qualified therapist while undergoing transition. The therapist can work with you, your family and friends and your school staff.

What are my Responsibilities for the Ongoing Treatment of My Child if Estradiol is Prescribed?

- To support your child in using estradiol for gender affirming hormonal therapy as prescribed, you agree to tell your child's health care provider if your child has any problems or side effects or is unhappy with the medication.
- You or your child can choose to stop taking this medication at any time. You know that if you or your child decides to stop estradiol therapy, you need to make a safe plan to stop the medications with the help of your child's health care provider.
- During treatment, your child should be working regularly with a mental health provider knowledgeable in gender incongruence.

You agree to the following:

- Schedule and bring your child to required check-ups to make sure that they are responding as expected to the medication.
- Tell your child's provider about any other medications, vitamins, supplements or other substances that your child uses.
- Tell your child's provider and make a safe plan to stop medications if your child decides that they want to stop estradiol.
- Discuss any questions and concerns about: estradiol treatment; adjustment concerns related to your child's social environment and their gender affirmation process; and/or changes in your child's family, school, or social systems of support, either positive or negative.
- Ensure your child maintains a therapeutic relationship with a mental health provider.

What Are the Alternatives to Estradiol Therapy?

- Non-medical interventions to support you or your child's gender dysphoria/gender incongruence, such as supporting you or your child's gender expression (i.e., clothing, hair style, hair removal), social transition (i.e., use of chosen name and pronouns) and working closely with a knowledgeable mental health provider. These non-medical interventions may help reduce some of your or your child's gender dysphoria but will not feminize the body.
- Voice therapy can be pursued to safely develop a more female-typical voice and speech pattern. This may be helpful in reducing gender dysphoria but may not be covered by your insurance.
- Estradiol therapy will not be started. The medical risks of estradiol would be avoided but may result in persistent gender dysphoria.

The signatures below confirm that:

Children's Wisconsin

Kids deserve the best.

- My or my child's healthcare providers spoke with me/us about the benefits and risks of taking estradiol, the possible or likely consequences of estradiol therapy and potential alternative treatments.
- I (We) have read this information and understand the risks that may be involved.
- I (We) understand there may be unknown long-term effects or risks.
- I (We) have had enough opportunity to discuss treatment options with healthcare providers.
- All my (our) questions have been answered to my (our) satisfaction.
- This consent form is valid for the duration of the estradiol therapy or until the patient or parent/legal guardian revokes their informed consent/assent or a significant complication occurs.

Parent or Legal Guardian Name (printed)	Relationship to Patient
Parent or Legal Guardian Signature	Date
Parent or Legal Guardian Name (printed)	Relationship to Patient
Parent or Legal Guardian Signature	Date

This consent was obtained and signature(s) witnessed by:

Provider Signature	Date

Second Witness for telephone or telemedicine consent:

Signature	Date

5

Children's Wisconsin

Kids deserve the best.

Patient Assent

The signature below confirms that:

- I want to begin taking feminizing medications (estradiol).
- I agree to take the estradiol as prescribed. I will not purchase estradiol or any other forms of estrogen or other hormones without my physician's knowledge, and I will tell my healthcare providers if I have any problems or am unhappy with the treatment.
- I assent to taking estradiol for gender affirming therapy and agree to comply with the recommendations of my health care provider.

_____

Patient Legal Name (printed)

_____ _____

Patient Legal Signature Date

Division of Endocrinology 4/2023

APPENDIX N – Informed Consent for Puberty Blockers

Informed Consent for Puberty Blockers (Gender Affirming Hormone Therapy)

Please read this form. Ask questions if you do not understand before you sign.

Please read the below information carefully and have a conversation with your child's medical provider. Ask your child's medical provider if you have any questions you have about treatment or alternative treatments. When you are comfortable and understand how puberty blockers may help your child, you may sign the consent to start treatment with puberty blockers.

Treatment

What are Puberty Blockers?

The physical changes of puberty can temporarily be put on hold with the use of puberty blocker medication. The use of puberty blockers for treatment of gender dysphoria and gender incongruence is based on current medical guidelines and research. Specific guidelines for the use of puberty blockers to treat patients with gender dysphoria or gender incongruence are available from the Endocrine Society and the World Professional Association of Transgender Youth.

These medications have been used to help treat patients for many years; however, these medications are considered "off label" for this purpose. The term "off-label" means that the medication has not been approved as safe and effective by the US Food and Drug Administration for this specific indication of use. The medication and dose that is recommended is based on the judgment and experience of the healthcare providers and the information that is currently available in the medical literature.

Puberty blockers may be used for up to a few years, with most therapy courses lasting 2 to 4 years. Some children may use puberty blockers until there is a decision to start gender affirming hormone therapy with testosterone or estradiol. Others may use puberty blockers for a period of time until there is a decision to stop therapy and let their own puberty start up again. These decisions require on-going conversations among the child, family members, the medical provider, and the mental health provider. Puberty blockers are not continued for any longer than they are deemed helpful to the child.

Puberty blockers are "gonadotropin-releasing hormone agonists" that stop the signal from the brain to the organs that make sex hormones (estradiol or testosterone). This prevents the ovaries from making estradiol and the testicles from making testosterone. Without estradiol or testosterone, there is no progression of puberty. This means, there would be no further breast growth in someone with ovaries or no increase in penis size in someone with testicles during treatment. This does not halt all changes related to puberty; underarm and pubic hair will continue to grow.

Puberty blockers do not undo any puberty changes that have already occurred. One should not expect breast growth to go away or the penis to get smaller, for example. If the puberty blocker is stopped or removed, the brain starts sending signal to the ovaries or testicles again, estradiol or testosterone levels increase, and puberty resumes. It can take months for puberty to begin after treatment is stopped but studies show return of normal sex hormone levels and normal pubertal development after treatment is stopped.

1

How are Puberty Blockers Taken?

Puberty blockers can be given as a series of injections into the muscle or subcutaneous fat, or as a single implant placed under the skin. Different forms of the injections can work to suspend puberty up to 1, 3, or 6 months and the implant can last up to 12 to 18 months. The type of puberty blocker chosen is typically based on patient/family preference and insurance coverage.

What are the Benefits of Puberty Blockers?

- Puberty blockers are used to help temporarily suspend or block the physical changes of puberty, although it can take several months for the medication to be effective.
- While taking these medications, your child's body will not be making the hormones of puberty (testosterone or estradiol).
- Puberty blockers may cause a single vaginal bleed in some people with ovaries as the medication starts working. This is normal. Your child should not have more vaginal bleeds on this medication after that first bleed.
- The medication's effect of puberty suppression is not permanent and is dependent upon on-going use of the medication. If your child stops taking the medication, the changes of puberty will resume.
- This pause in puberty may be helpful in reducing your child's distress or anxiety from puberty changes developing in a way that does not match their gender identity. This allows you and your child time to work with a mental health provider and further explore your child's gender identity.
- If you stay on puberty blockers and then later start gender affirming hormone therapy, your child may be able to avoid some future gender affirming surgeries and other treatments (i.e. chest reconstruction or augmentation, facial surgeries, electrolysis) that may otherwise be desired.
- Your child and your family may benefit from mental health support to reduce stress and improve or maintain the ability to cope with everyday life and medical treatments. Your child is required to maintain a therapeutic relationship with a mental health provider as part of the treatment plan.

What are the Risks and Possible Side Effects of Puberty Blockers?

- These medications have been administered to children for other diagnoses for many years, safely. However, the long-term side effects and safety of these medicines are not completely understood.
- Because puberty blockers reduce estradiol and testosterone levels, this medication slows the puberty growth spurt. Your child will grow, but at a slower speed. If treatment is stopped or if your child starts gender affirming hormones, they will start growing faster again.
- Puberty blockers reduce bone density. Research shows that delays in bone density generally reverse after puberty is resumed or gender affirming hormones are started. To maximize bone density while on puberty blockers, you should take calcium and vitamin D supplementation and engage in weight-bearing physical activity. These interventions do not completely reverse the effects of puberty blockers on bone density but are helpful.
- Puberty blockers reduce the growth of the external and internal genitalia. In those with ovaries, there is less growth of the uterus and vagina. In those with testicles, there is less growth of the scrotum, testicles, and penis. This may make any future genital reconstructive surgery more difficult as there is less tissue to work with. Please note that if puberty blockers are stopped and biologic puberty starts again, your child would experience typical growth of the external and internal genitalia.

- Puberty blockers prevent the maturation of sperm in the testicles or eggs in the ovaries.
    - If you stop the blockers, your child's puberty would start up again and there would be maturation of sperm or eggs and fertility would be normal over time.
    - If you start gender affirming hormones after using puberty blockers, your child will not develop fertile (mature) sperm or eggs.
    - If future fertility is desired at any point after blocker therapy is started, your child would have to stop puberty blockers (and, if started, stop gender affirming hormones) and allow their biological puberty to progress to completion. This would also mean that your child would develop all the usual secondary characteristics typical of their assigned sex at birth. This process could take several years and there would be no guarantee of fertility. p
- There is a risk of increased pressure inside your head. This can cause headaches, nausea, double vision and, in severe cases, vision loss. Your providers will check for these problems at each visit. Please let your provider know if any of these symptoms occur.

What are My Responsibilities for the Ongoing Treatment of My child if Puberty Blockers are prescribed?

- To support your child in taking puberty blockers as prescribed, you agree to tell your child's health care provider if your child has any problems or side effects or is unhappy with the medication.
- To understand that using these medicines to block puberty is an "off-label" use. This means it is not approved by the US Food and Drug Administration for this specific use. You know that the medication that is recommended is based on the judgment and experience of your child's health care providers and is based on the recommendations of the Endocrine Society and the World Professional Association of Transgender Health.
- You or your child can choose to stop taking these medications at any time. You know that if you or your child decides to stop puberty blocker therapy, you need to make a safe plan to stop the medications with the help of your child's health care provider.
- To reduce the risks of side effects, you understand that puberty blocker therapy is a temporary intervention to reduce distress and improve mental/behavioral health and physical outcomes in your child. Puberty blockers allow you to make well-informed decisions about whether gender affirming hormone therapy is needed/desired or if biologic puberty should resume. During treatment, your child should be working regularly with a mental health provider knowledgeable in gender dysphoria and gender incongruence. You know that the medical team cannot continue puberty blockers indefinitely.

You agree to the following:

- Schedule and bring your child to required check-ups to make sure that they are responding as expected to the medications.
- Tell your child's provider about any other medications, vitamins, supplements, or other substances that your child uses.
- Tell your child's provider and make a safe plan to stop medications if your child decides that they want to stop blocking their biological puberty.
- Discuss any questions and concerns about puberty suppression treatment; adjustment concerns related to your child's social environment and their gender affirmation process; changes in your child's family, school, or social systems of support either positive or negative.
- Maintain a therapeutic relationship with a mental health provider.

What are the Alternatives to Puberty Blockers?

- Non-medical interventions to support your child's gender dysphoria/gender incongruence such as supporting their gender expression (i.e., clothing, hair style, hair removal), social transition (i.e., use of chosen name and pronouns), gender-affirming voice therapy, and working closely with a knowledgeable mental health provider. These non-medical interventions may help reduce some of your child's gender dysphoria but will not prevent the development of puberty changes.
- Transgender girls could consider the anti-androgen medication called spironolactone. Spironolactone blocks some of the action of testosterone at the hair and skin follicles and, over time, results in less facial and body hair and softer skin. Spironolactone does not prevent voice deepening or masculinization of the face and body. Spironolactone can be discussed separately with your medical provider.
- Transgender boys could consider use of binders to minimize the appearance of chest growth if the breasts are distressing. Transgender boys could also consider menstrual suppression if periods start and are distressing. This could be by using combined oral contraceptive pills, oral or injected progesterone, or placement of an intrauterine device (IUD). These interventions will not prevent breast growth or feminization of the face and body. These options can be discussed separately with your medical provider.
- Puberty blocker therapy would not be started. The medical risks of puberty blockers would be avoided but your child will have development of puberty changes that they may find distressing. Once puberty changes develop, they are generally permanent.

What this means?

The signatures below confirm that:

- My child's healthcare providers spoke with me about the benefits and risks of taking puberty blockers, the possible or likely consequences of taking puberty blockers and potential alternative treatments.
- I understand the treatment is considered off-label at this time.
- I have read this information and understand the risks that may be involved.
- I understand there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with healthcare providers.
- All my questions have been answered to my satisfaction.
- This consent form is valid for the duration of the puberty blocker therapy or until the parent/legal guardian revokes their informed consent or a significant complication occurs.

Parent or Legal Guardian Name (printed)	Relationship to Patient
Parent or Legal Guardian (signature)	Date
Parent or Legal Guardian Name (printed)	Relationship to Patient
Parent or Legal Guardian (signature)	Date

This consent were obtained and signature(s) witnessed by:

_____ _____

Provider signature Date

Second Witness for phone consent:

_____ _____

Signature Date