



5930 E Pima Street Suite 138, Tucson AZ 85712 . phone 520-441-4006 . fax 855-249-5320

Presurgical Psychological Evaluation Informed Consent

Name of Patient: _____

Patient DOB: _____

Referral Source: The above named patient has been referred for a presurgical psychological assessment by (circle one, and specify if appropriate):

Self/Parent Medical Provider: _____

Planned Surgical Procedure: _____

Nature and Purpose of Assessment: The purpose of a presurgical psychological assessment is multifactorial: (1) to determine a patient's understanding of the nature of the planned procedure, including assessment of their understanding of the potential risks and benefits associated with the procedure, (2) to assess their preparation for any lifestyle changes that will be required in the aftermath of surgery, with care to assess factors relating to their current physical and emotional support system, and (3) to assess present and past psychiatric functioning, with care to determine whether any (additional) psychological treatment supports might be advised either prior to or following the planned procedure. All presurgical assessments will include an in-depth clinical interview, a mental status screening, and completion of a handful of mood screening measures. Depending upon the nature of the procedure, personality assessment (particularly as it relates to factors relevant to medical interventions), simple and/or in-depth neurocognitive screenings/assessments may also be included.

Foreseeable Risks, Discomforts, and Benefits: Psychological and neurocognitive assessment procedures can contribute to fatigue, frustration and/or anxiety in some patients. For lengthier assessments, sessions may be spread across multiple service dates in order to minimize the likelihood of these risks/discomforts. Regular breaks will also be offered, and assessments can be discontinued at any time at the request of the patient, his/her parent/guardian, and/or the evaluator.

Fees and Time Commitment: By signing this form, you are attesting that you have been provided specific information relating to the fees for this service. You are also acknowledging that you are ultimately responsible for any and all fees not covered by the fee arrangement, by pre-payment or by insurance. Assessments generally require an hour or more of diagnostic interviewing time and an hour or more of questionnaire completion (both paper- and computer-based). Assessments may also include face-to-face testing. Additional time is also required for scoring, interpretation and report preparation.

Limits of Confidentiality: Information obtained during assessments is confidential, and can generally be released only with your written permission. **If the listed patient was referred by an existing medical treatment provider, your signature on this form indicates your permission for the summative evaluative report to be released directly to this provider in order to facilitate continuity of care.** The report will not be released to another party without your written permission, except in the case of special circumstances as delineated below. If this was a self-referral, the report will be released only to you, with further release limited to cases of your written permission except in the case of special circumstances as delineated below.

There are some special circumstances that can limit confidentiality. When present, these circumstances render the evaluator *legally required* to release information that would otherwise be considered confidential. These circumstances include: (a) given a statement of intent to harm self or others, (b) given statements suggesting ongoing harm or abuse of children or vulnerable adults, and/or (c) given legal requests for records or information release either through subpoena (where release may be more limited in scope) or court order (where all information is generally vulnerable for release) as issued formally by a court of law.

Statement Regarding the Voluntary Nature of the Present Assessment: Your or your child's participation in this evaluation is completely voluntary. The evaluation will not be completed without your signature on this document, and you have the right to stop the evaluation at any time. You also have the right to decline to answer specific questions asked by this writer during the evaluation, though depending on the purpose of the evaluation the evaluator may indicate in the evaluative report those questions you declined to answer.

I have read and agree with the nature and purpose of this assessment and to each of the points listed above. I have also been given ample opportunity to clarify any questions I have and to discuss any points of concern directly with the evaluator before signing.

Patient Signature

Date

Parent/Guardian or Authorized Surrogate Signature

Date

Printed Name of Person Providing Consent

Relationship to Patient

Witness Signature

Date