



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

INTRODUCTION

In early 2007, the Minnesota Alliance for Patient Safety (MAPS) convened a work group to develop a statewide informed consent process. The impetus occurred when the Centers for Medicare and Medicaid Services (CMS) issued new Conditions of Participation (May 2004) and interpretive guidelines (April 2007). These guidelines required that a written informed consent process and form informs the patient of his or her health status, allows patients to be part of care planning, and provides the opportunity for patients to object to particular treatments.¹

The right to make informed decisions is dependent upon the patient's and/or their representative's ability to fully comprehend the treatment to which they are consenting. The patient and/or their representative should receive information in a manner and language that is understandable to them. It was evident upon review of existing informed consent forms that the role of health literacy has not been considered and forms are often not comprehensible to the patient. During times of illness and stressful events, all patients could benefit from easy to understand health care forms. A lower literacy level form does not preclude an in depth conversation with those patients with higher levels of understanding. The form is designed to be at a minimum standard that all patients can understand. The MAPS template informed consent reads at a 4.5 grade reading level.

MAPS set out to develop a template form that every outpatient setting could utilize to facilitate the informed consent process and that every hospital and surgical center in Minnesota would accept as comprehensive informed consent documentation. The form includes all elements that make up a "well-designed informed consent form" as defined by CMS. This form also incorporates standards set by The Joint Commission and Occupational Safety and Health Administration (OSHA).

MAPS envisions this form as Minnesota's universal documentation of informed consent and that health care organizations statewide use the informed consent form and accompanying policy with no variation. If this form is used, the MAPS logo should be included along with an organizational logo. However, at minimum, all of the elements must be included if represented as a MAPS form..

WHAT IS WRITTEN INFORMED CONSENT?

"Written informed consent," means that the patient and clinician have signed a document acknowledging that:

- A. The patient has been provided information necessary to make an informed decision about a proposed medical treatment or procedure (the necessary information is listed on page 2 and 3 of this policy)
- B. The clinician has discussed the procedure with the patient and answered the patient's questions; and
- C. The patient consents to the procedure.

PURPOSE OF THE INFORMED CONSENT PROCESS

Informed consent involves much more than just obtaining a signature. The informed consent process is ongoing and interactive. The process might begin in the outpatient office; involve several providers; and occur over time rather than occur as a one-time information session prior to procedure. It is expected that all treatment decisions will be made only after a fully informed and shared decision-making discussion between the patient and clinician.

¹ Requirements related to informed consent for hospitals are found in the Patients' Rights Condition of Participation (CoP) at 42 CFR 482.13(b)(2); the Medical Records CoP at 482.24(c)(2)(v); and the Surgical Services CoP at 482.51(b)(2). Interpretive guidelines for Tags A-0049 (Patients' Rights), A-0238 (Medical Records), and A-0392 (Surgical Services) replace the guidelines issued in May 2004.



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

The right to make informed decisions regarding care presumes that the patient has been provided information about his/her health status, diagnosis, and prognosis. Furthermore, it includes the patient's participation in the development of the plan of care, including consent to or refusal of medical or surgical interventions and in planning for care after discharge from the facility. Again, the patient or the patient's representative should receive adequate information, provided in a manner that they can understand. This assures that the patient can effectively exercise the right to make informed decisions.

INFORMATION THAT MUST BE PROVIDED TO THE PATIENT DURING THE INFORMED CONSENT CONVERSATION

For informed consent to be complete, the clinician must discuss in language and in a form that the patient can at least the following information. The clinician must take reasonable steps to ensure that the patient understands the information provided (e.g., avoid technical jargon, ask whether they understand, encourage questions, use the "teach back," method). For example, with "teach back" method, the provider would ask the patient to restate what he or she understands to be the nature and risks of the procedure to be.

It is the facility's responsibility to assure, via established processes, that each patient or patient's representative is given information on the patient's health status, diagnosis, and prognosis.

The clinician's signature on the informed consent form or note in the record certifies the following information was provided.

- A. The indications for the proposed surgery or other invasive procedure;
- B. A description of the proposed surgery or other invasive procedure, including the anesthesia to be used;
- C. Material risks and benefits for the patient related to the surgery or other invasive procedure and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity. A relatively minor risk may be significant to a particular patient. If the clinician knows that the risk would be important to that patient's decision-making the clinician should discuss the risk with the patient;
- D. Treatment alternatives, including the attendant material risks and benefits;
- E. The probable consequences of declining recommended or alternative therapies;
- F. Who will conduct the surgical intervention and administer the anesthesia, if known;
- G. Whether physicians other than the operating practitioner, including but not limited to residents (*see note*), will be performing important tasks related to the surgery or other invasive procedure, in accordance with the hospital's policies. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines;

Note: For surgeries or other invasive procedures in which residents will perform important parts of the surgery or other invasive procedure, discussion is encouraged to include the following:

- A. It is anticipated that physicians who are in approved post graduate residency training programs will perform portions of the surgery or other invasive procedure, based on availability and level of competence;
- B. It will be decided at the time of the surgery or other invasive procedure which residents will participate and their manner or participation, and that this will depend on the availability of residents with the necessary competence; the knowledge the operating practitioner/teaching surgeon has of the resident's skill set; and the patient's condition;



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

- C. Residents performing surgical tasks will be under the supervision of the operating practitioner/teaching surgeon.
- D. Whether, based on the resident's level of competence, the operating practitioner/teaching surgeon will not be physically present in the same operating room for some or all of the surgical tasks performed by residents.
- E. Whether, as permitted by State law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out; and that such practitioners will be performing only tasks within their scope of practice for which they have been granted privileges by the hospital.

PURPOSE OF INFORMED CONSENT FORM

Minnesota health care facilities recognize a patient's right to give knowing, voluntary consent before receiving medical treatment. The purpose of the informed consent form is to verify that the *process* of informed consent has occurred between the patient and the clinician.

Signing the form should be the last step in this process. The informed consent form serves as a mechanism to confirm the patient understands the procedure and provides an opportunity for patients to ask additional questions about their procedure and the facility.

A properly executed informed consent form must be placed in the patient's medical record prior to surgery, except in the case of emergency surgery.

INFORMATION THAT MUST BE INCLUDED ON THE INFORMED CONSENT FORM

A "properly executed" informed consent form should reflect the patient consent process. Except as specified for emergencies in the hospital's informed consent policies, all inpatient and outpatient medical records must contain a properly executed informed consent form prior to conducting any procedure or other type of treatment that requires informed consent.

An informed consent form, in order to be properly executed, must be consistent with hospital policies as well as applicable State and Federal law or regulation.

A "properly executed" informed consent form contains the following minimum elements:

- A. Name of the hospital where the procedure or other medical treatment is to take place; Name of the specific procedure, or other type of medical treatment for which consent is being given;
- B. Name of the responsible practitioner who is performing the procedure or administering the medical treatment;
- C. Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, *was explained* to the patient or the patient's legal representative;
- D. Signature of the patient or the patient's legal representative;
- E. Date and time the informed consent form is signed by the patient or the patient's legal representative.

A "well-designed informed consent form" might also include the following additional information:

- A. Statement, if applicable, that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner.



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

- B. Statement, if applicable, that qualified medical practitioners who are not physicians who will perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital.
- C. Listing of the material risks of the procedure or treatment that were discussed with the patient or the patient's representative;
- D. Name of the practitioner who conducted the informed consent discussion with the patient or the patient's representative.
- E. Date, time, and signature of the person witnessing the patient or the patient's legal representative signing the consent form.

DOCUMENTATION OF CONSENT

When written consent is required, the clinician and patient must certify that the informed consent discussion has occurred and the patient is consenting to the procedure by signing the informed consent form. The form must include the minimum elements detailed on page 5, whether from the facility where the procedure is occurring or from the outpatient setting. The signed form must be placed in the patient's medical record.

1. **Clinician's Signature:** As a rule, the clinician must sign the informed consent form before the facility will permit the procedure to be performed. If the procedure is ordered by the clinician but is administered by a non-clinician (e.g., a blood transfusion or insertion of a central line) and the clinician cannot be physically present to sign the form prior to the procedure, the clinician may certify that the informed consent conversation took place and that the patient consented. The clinician must follow the facility's procedure for accepting an order by telephone.
2. **Verification of patient's signature by witness:** When written consent is required, the facility should verify that the signature on the informed consent form is that of the patient. However, it is not necessary for a facility employee to witness personally the informed consent conversation between the clinician and patient nor the patient signing the form.
 - A. *Employee witness observes patient signing:* A facility employee who observes the patient signing the form may verify that fact by signing the informed consent form as a witness to the signature.
 - B. *When signed out of employee witness's presence:* If the form was signed by the patient out of the presence of a facility employee, an employee must confirm with the patient that the signature on the form is that of the patient and that the patient consents to the procedure. The employee must sign the informed consent form as a witness.
 - C. *When signed out of employee witness's presence and witness has signed:* If another witness (e.g., a nurse in the clinician's office) has already signed the form, the facility employee may co-sign the form or note in the record that the employee verified the patient's signature.

When written consent is *not* required, the clinician may document the discussion and the patient's consent in a progress note stating that the informed consent process has occurred. Such a note certifies that the clinician has provided the information required and that the patient consented to the procedure. The clinician may – but is not required to – use the informed consent form to guide the informed consent discussion and to document the patient's consent, even when written consent is not required.



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

PRACTITIONER'S RESPONSIBILITY

Obtaining informed consent is the responsibility of the practitioner(s) responsible for performing the procedure and cannot be delegated to anyone else. A practitioner has the legal and ethical obligation to administer a medical treatment or procedure to a patient only if the patient has given the clinician informed consent to the treatment or procedure.

The practitioner who performs or orders the treatment or procedure is personally responsible for ensuring and certifying in the record that the informed consent process has taken place and that the patient has consented to the treatment or procedure. Exceptions to this include where informed consent is not possible without a serious threat to life or limb or if legally authorized by a court or judge.

The responsible practitioner is the practitioner(s) responsible for performing the procedure. However, in cases where other practitioners actually perform the procedure it is the practitioner that supervises or orders the procedure.

A practitioner may collaborate with other practitioners who assist in this process or use patient education tools (i.e., video, written information sheets), however, it is the ordering, administering, or supervising practitioner that is responsible for obtaining the patient's informed consent and certifying that the process has occurred.

FACILITY'S RESPONSIBILITY

For procedures requiring written informed consent, the facility must assure the patient's right to make informed decisions by requiring practitioner(s) responsible for the surgery to obtain informed consent in a manner consistent with the policies governing the facility's informed consent process. The consent form is often provided by the facility and signed by the clinician and patient; however, the process may be initiated in the outpatient setting using a standardized form. For procedures requiring written informed consent, the facility must verify that written informed consent is in the patient's record before permitting the procedure to be performed.

SCOPE OF INFORMED CONSENT

The scope of a patient's consent depends on what the clinician has discussed and what the patient has consented to. The scope of consent must be clear. It is important that the clinician explains and the patient understands the scope of what is being recommended, that both the clinician and patient are clear as to what the patient has consented to, and that their understanding is clearly documented on the informed consent form or elsewhere in the record.

A patient may consent to a one-time treatment or procedure (e.g., colonoscopy), routine care of a particular condition that may include a variety of discrete procedures or treatments (e.g., pre-natal care), or for a series of the same treatment (e.g., dialysis or blood transfusions during a hospital stay).

The patient can rescind consent at any time, especially when the scope covers several encounters.

PROCEDURES THAT MAY REQUIRE MORE THAN ONE CONSENT FORM

Sometimes several discrete procedures are ordered and administered by more than one physician (e.g., anesthesia before surgery, blood transfusion not related to surgery). In such a case, clinicians may obtain the patient's consent to the respective procedures on a single form.



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

If a single form is used, each clinician's signature certifies that the pertinent information for each procedure was discussed with the patient. If the form clearly identifies the procedures being consented to and is signed by both clinicians, facilities may use a different form for each procedure or treatment.

However, given that surgical procedures generally entail use of anesthesia, hospitals may wish to consider specifically extending their informed consent policies to include obtaining informed consent for the anesthesia component of the surgical procedure.

The informed consent form for surgery or invasive procedures does not include necessary informed consent required for research.

Federal and Minnesota state regulations require additional documentation and consent for hysterectomy and sterilization.²

Hysterectomy - Department of Health and Human Services (DHHS) requires a hysterectomy acknowledgement statement (HAS). Below is a sample HAS. It is not mandatory for the provider to use this sample acknowledgment statement. Any document that the recipient, or her representative, has signed that shows the provider informed the recipient that she would be incapable of reproducing due to the hysterectomy is permissible

Sample Hysterectomy Acknowledgment Statement

My doctor informed me, both orally and with written materials, that the performance of a hysterectomy would make me sterile (not able to have children).

Signed _____ Date _____

Note: If the recipient signs the acknowledgment after the hysterectomy, the acknowledgment must show that the recipient was informed of the consequences of the hysterectomy before the procedure was performed.

Sterilizations - This requires exact language, and a DHHS approved form. This form is required by DHHS/CMS for Medicaid paid sterilizations and must be submitted with the bill. Any alternate form would have to be approved the Secretary of DHHS. The brochures with the specific federal consent form are available at:

² Requirements related to hysterectomy and sterilizations are under Title 42: Public Health Subpart F—Sterilizations § 441.258 Consent form requirements and § 441.256 Additional condition for Federal financial participation (FFP). The Minnesota Department of Human Services MHCP provider manual, chapter 10- Sterilizations is available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137815



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

- Men's English: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-2511-ENG>
- Women's English: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-2510-ENG>
- Men's Spanish: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-2511-SPA>
- Women's Spanish: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-2510-SPA>

WHEN WRITTEN INFORMED CONSENT IS REQUIRED

“Surgery” includes any procedure that is listed as a surgical procedure in the various billing or coding systems used by CMS or the hospitals, (e.g., CPT) regardless of whether Medicare pays for that surgical procedure. Facility policy should specify which procedures are considered surgery and therefore are those that require a properly executed informed consent form. Medical staff by-laws should address which procedures and treatments require written informed consent

1. While a clinician should always communicate and collaborate with the patient regarding the patient's health care, federal and state law, rules of accrediting organizations and similar regulatory bodies require written informed consent for the following procedures:
 - A. Surgical procedures (not including simple laceration repair and minor dermatological procedures performed in out-patient settings);
 - B. Experimental procedures or treatment;
 - C. Abortion;
 - D. Administration of blood or blood products (if not related to the surgery/invasive procedure);
 - E. Electro-convulsive therapy (ECT);
 - F. Neuroleptic medication when prescribed for the treatment of mental illness or mental retardation, but not when prescribed for other purposes;
 - G. Any medical treatment necessary to preserve the life or health of a patient committed under the Minnesota Civil Commitment and Treatment Act;
 - H. Radiation therapy;
 - I. Invasive medical imaging;
 - J. Procedures involving moderate to deep sedation where there is a risk of loss of protective reflexes. (a separate anesthesia-specific consent form should be considered)
 - K. Surgical or other invasive procedures are those involving a skin incision or puncture including, but not limited to: open surgical procedures, percutaneous aspiration, selected injections, biopsy, percutaneous cardiac and vascular diagnostic or interventional procedures, laparoscopies, endoscopies, and excluding venipuncture or intravenous therapy. Specific examples of other invasive procedures that require written informed consent are as follows:
 - Injections of any substance into a joint space or body cavity;
 - Percutaneous aspiration of body fluids through the skin (e.g., arthrocentesis, bone marrow aspiration, lumbar puncture, paracentesis, thoracentesis, suprapubic catheterization);
 - Biopsy (e.g., breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin);
 - Cardiac procedures (e.g., cardiac catheterization, cardiac pacemaker implantation, angioplasty, stent implantation, intra-aortic balloon catheter insertion);
 - Central vascular access device insertion (e.g., Swan-Ganz catheter, percutaneous intravascular catheter (PIC) line, Hickman catheter);
 - Electrocautery of skin lesion;



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

- Endoscopy (e.g., colonoscopy, bronchoscopy, esophagogastric endoscopy, cystoscopy, Percutaneous Endoscopic Gastrostomy (PEG), and J-tube placements, nephrostomy tube placements);
 - Laparoscopic surgical procedures (e.g., laparoscopic cholecystectomy, laparoscopic nephrectomy);
 - Invasive radiology procedures (e.g., angiography, angioplasty, percutaneous biopsy);
 - Laser therapy (e.g., eye, ear, nose, and throat (ENT));
 - Dermatology Procedures (biopsy, excision and deep cryotherapy for malignant lesions - excluding cryotherapy for benign lesions);
 - Invasive ophthalmic procedures, including miscellaneous procedures involving implants;
 - Oral surgical procedures including tooth extraction and gingival biopsy;
 - Podiatric invasive procedures (removal of ingrown toenail, etc.);
 - Skin or wound debridement performed in an operating room; and
 - Renal dialysis.
- L. Diagnostic procedures that carry a significant, material risk;
- M. Circumcision;
- N. Sterilization; see above federal and state regulations that require additional documentation and consent for sterilization.
- O. Continuation of a do-not-resuscitate or -intubate order (DNR or DNI) during surgery if the patient has a DNR or DNI order in place.

EXCEPTIONS TO INFORMED CONSENT REQUIREMENT

The facility may permit a clinician to provide or order treatment without the patient's informed consent under two circumstances.

1. **Emergencies.** If an emergency medical condition makes it impossible or impractical to obtain informed consent without jeopardizing the patient's life or health, emergency treatment may be provided to preserve the patient's life or health. The emergency exception does not apply if the patient has previously clearly made known that he or she does not wish to receive the proposed emergency treatment under the present circumstances. The facts that make the situation an emergency must be documented in the patient's medical record. Emergency treatment under this exception may continue until the patient gains decision-making capacity, or until the patient's family or legal representative is available to make decisions on the patient's behalf, at which time informed consent must be obtained from the patient or the patient's representative.

2. **Court-ordered treatment.** Treatment may be provided to an individual without the individual's informed consent and over the patient's objection if ordered by a court. The court's order authorizing treatment must be documented in the patient's record.

TIMELINESS OF INFORMED CONSENT

1. The clinician must obtain the patient's informed consent *before* the procedure is administered, at a time that the patient is not sedated, and when the patient's judgment is not otherwise impaired.
2. If there is a delay between when the patient initially consented and when the procedure is performed, the patient's consent remains valid unless:



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

- A. There has been a significant deviation from the treatment plan to which the patient originally consented, in which case the patient must be informed of and consent to the change in plans; or
- B. Facts have changed since the clinician's discussion with the patient such that it would be reasonable for the patient to be informed of the change and asked to consent again in light of the changed facts, in which case the patient must be informed of the new facts and be asked consent in light of them; or
- C. The patient has revoked consent, in which case the procedure may not be performed.

Even if there has been no significant change, a clinician should discuss the proposed treatment with the patient again if more than 30 days have passed between the initial discussion and consent and the day that the procedure will be administered. It is not necessary to sign a new consent form if the clinician documents the discussion in the patient's record.

WHO CAN GIVE INFORMED CONSENT

1. Patient with decision-making capacity: A patient with decision-making capacity is the only person who may consent to his or her own treatment. While the patient may include and consult with others in the patient's decision-making process, the clinician must not proceed with the procedure unless the patient consents. In general, a person lacks capacity if the person (1) does not demonstrate a general awareness of his or her health situation and the treatment being proposed; (2) cannot understand the factual information provided about the recommended treatment, especially its risks and benefits; *or* (3) cannot communicate – verbally or nonverbally – a clear decision regarding the treatment based on that information.

The clinician should assess the patient's capacity each time the patient is asked to consent to a procedure. If the clinician determines that the patient lacks capacity to give or withhold consent, the facts supporting that determination must be documented in the patient's medical record.

2. Adults: In general, an adult age 18 or over is presumed to have decision-making capacity unless there is convincing evidence to the contrary. If a clinician concludes that a patient lacks capacity, he or she should note in a patient's record the facts and reasons supporting that decision. This presumption does not apply if the person has been found by a court to currently have diminished decision-making capacity; for example, a person whose court-appointed guardian has been given the power to make medical decisions.

Disagreement with the recommendation of a health care professional is not evidence of incapacity.

3. A patient without decision-making capacity: If a patient lacks decision-making capacity, informed consent must be obtained from a representative of the patient. The first person on the following list who is available and willing to serve may be recognized as the patient's representative:
 - A. A parent or guardian if the patient is a child age 17 or younger;
 - B. A court-appointed guardian with authority to make health care decisions for the patient;
 - C. A health care agent named by the patient in a health care directive, health care power of attorney, or similar document; or
 - D. A friend or relative of the patient who knows the patient well enough to know what the patient would decide if they had the capacity and who is willing to make decisions on the patient's behalf.

NOTE: Except for patients being treated under the Minnesota Civil Commitment and Treatment Act, *there is no prescribed order or hierarchy of relatives or friends who may act as the patient's representative.*

Depending on the circumstances, the representative may be the patient's spouse, life partner or companion, parent, adult child, neighbor, friend, or other person. The only necessary criterion is that the person know the



Minnesota Alliance for Patient Safety (MAPS) Statewide informed consent process – Model Policy

patient well enough to be able to state with reasonable confidence what the patient would likely decide if the patient were able to do so.

The clinician should consider the patient's representative to be the person who best knows the patient and what the patient would likely decide if the patient had capacity, and who will make decisions in accord with the patient's wishes. The hospital and clinic may assist the clinician in making this determination.

4. Joint decision-makers: More than one person may serve as the patient's representative. For example, a patient's health care directive may name two or more persons to act jointly as the patient's agent, or two adult children may act jointly as the representative for their incapacitated parent. If more than one potential representative is available and they cannot agree to act jointly, the clinician may decide who among the potential decision-makers will most likely make the decisions the patient would make and designate that person as the patient's representative for purposes of obtaining informed consent. The clinician is required to document the process by which the representative is determined.

The patient's representative should be asked whether the patient would have consented to the proposed treatment if the patient were capable of making the decision. If it is impossible to know what the patient would have chosen, the representative may make the decision based on what is in the patient's best interest. The clinician should document in the patient's medical record the process used to determine who will be the decision-maker and the reasons for the clinician's determination.

5. Children: A person younger than 18 years is presumed not to have legal capacity to make health care decisions and a parent or guardian must make health care decisions for the child. However, a child younger than 18 years has legal capacity to give informed consent without the consent of anyone else in the following circumstances:
 - A. A person age 17 or younger may give (or withhold) informed consent to any medical care if the person
 - has borne a child; or
 - is married; or
 - lives apart from his or her parents or guardians and is managing his or her own financial affairs. The source or amount of the minor's income is not relevant.
 - B. Any person who is 17 or younger may give (or withhold) informed consent for treatment related to
 - pregnancy (including birth control) or sexually transmitted disease;
 - drug or alcohol dependency; or
 - admission for mental illness or chemical dependency, but only if an examiner determines that the child has mental illness or chemical dependency and is suitable for treatment.

A parent's consent to treatment does not impose an obligation on the clinician to provide it.