SOP: Verification of Patient Consent and Medical History Review

This SOP details the process for **verification of patient consent and medical history review**, ensuring that all patients provide informed consent prior to any medical procedure. It includes steps for confirming the accuracy and completeness of patient medical histories, verifying documentation, addressing patient questions and concerns, and maintaining compliance with legal and ethical standards. The goal is to enhance patient safety, improve treatment outcomes, and uphold patient rights through thorough consent and history verification.

1. Purpose

To establish a standard process for verifying patient consent and reviewing medical history prior to any medical procedure, in accordance with institutional, legal, and ethical guidelines.

2. Scope

This SOP applies to all healthcare staff involved in obtaining patient consent and reviewing patient medical histories in [Facility/Department].

3. Responsibilities

- Healthcare Providers: Obtain and verify patient consent; review and confirm accuracy of medical history; address
 patient questions.
- Nurses/Assistive Staff: Prepare documentation; assist in data collection.
- Administrators: Ensure SOP compliance and maintain records.

4. Procedure

1. Patient Identification

Verify patient identity using at least two identifiers (e.g., name, date of birth).

2. Medical History Review

- o Obtain/update comprehensive medical history from patient or legal guardian.
- Review current medications, allergies, past medical/surgical history, and relevant family/social history.
- Document history in the designated electronic medical record (EMR) or paper file.

3. Consent Process

- Explain the procedure, risks, benefits, and alternatives in language understandable to the patient.
- Allow time for questions; address all patient or guardian concerns.
- Provide written consent forms; ensure forms are read, completed, and signed in the presence of a witness if required.
- Confirm the consent document is correctly filled and filed in the patient record.

4. Verification and Documentation

- o Double-check documentation for completeness, legibility, and accuracy.
- Document date, time, and name/signature of staff obtaining consent and reviewing history.

5. Compliance and Confidentiality

 Ensure all personal health information is handled confidentially and stored securely per HIPAA/regulatory guidelines.

5. Documentation

Document/Form	Responsibility	Retention Period
Patient Consent Form	Provider/Nurse	Specified by facility policy
Medical History Record	Provider/Nurse	Specified by facility policy
Verification Checklist (if applicable)	Provider	Specified by facility policy

6. Training

All personnel must undergo initial and periodic training on informed consent procedures and patient information confidentiality.

7. Compliance

- Follow institutional, legal, and ethical standards.
- Report and document any variance or breach in procedure immediately.

8. Review and Revision

This SOP will be reviewed annually and revised as needed to ensure ongoing compliance and effectiveness.

9. References

- Institutional Policies & Procedures
- HIPAA Guidelines
- State/Federal Regulations on Patient Consent
- Relevant Ethical Standards