NewYork-Presbyterian
The University Hospital of Columbia and Cornell

45350

CONSENT FOR SURGICAL / INVASIVE PROCEDURE

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

I hereby give my consent and authorize Dr. Michael Kazim and NewYork-Presbyterian Hospital ("Hospital") and its staff to perform the following surgical/invasive procedure ("procedure") upon _____ (name of patient). **(Describe procedure, and if applicable the specific implant/implant system to be placed or device to be removed). (NO ACRONYMS OR ABBREVIATIONS EXCEPT FOR SPINAL LEVELS):**

_____

_____

Procedure Site - Check applicable box(es)

☐ Right-side ☐ Left-side ☐ Bilateral ☐ Spinal Level(s) _____ ☐ Digit(s) _____

Michael Kazim MD _____ **explained to me, in a way that I understand, the following:**
(Name of Physician/Appropriately Credentialed Practitioner)

1. The nature, purpose, and the reasonably foreseeable risks and benefits of the procedure; the alternatives, including not performing the procedure, as well as the reasonably foreseeable risks and benefits of the alternatives;
2. That the practice of medicine is not an exact science and the procedure may not result in the intended benefits;
3. That there are risks associated generally with anesthesia, surgery, use of medication, medical procedures and treatments not ordinarily anticipated which can cause adverse consequences to my life or health; and
4. That other practitioners may assist with the procedure(s) as necessary, and may perform important tasks related to the surgery.

NOTE: If the patient is under eighteen (18) years, the permission of the patient's parent or legal guardian must be obtained, unless the patient is married or the parent of a child.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure(s) specified above. I understand that certain tubes, catheters, and lines may be placed during the procedure and I give my consent for replacement of those tubes, catheters, and lines as indicated. I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure, for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

_____ _____ _____ ____/____/_____ Time: _____ AM PM
(Patient/Health Care Agent/Guardian/Family Signature) (Printed Name) (Relationship to Patient) (Date)

By initialing here ☐ I consent to the use of film or recording of the procedure for internal educational and performance improvement purposes.

By initialing here ☐ I consent to the presence of a vendor during the procedure.

_____ _____ ____/____/_____ Time: _____ AM PM
(Witness' Signature) (Printed Name) (Date)

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved

I have discussed the nature, purpose, and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the reasonably foreseeable risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

_____ MD/NP/PA _____ ____/____/_____ Time: _____ AM PM
(Signature of Physician/Appropriately Credentialed Practitioner) Print Name/M.D. ID Code (Date)

Day of Surgery: Verification of correct procedure AND site/side: (to be completed on day of surgery by RESPONSIBLE provider performing the surgery or procedure)
Date: ____/____/____ Time: _____ AM/PM
☐ Right-side ☐ Left-side ☐ Bilateral ☐ Spinal Level (s) _____ ☐ Digit(s) _____
Signatures
Patient/Health Care Agent/Guardian/Family Signature: _____
RN: _____ RN: (Print Name) _____
Physician/Appropriately Credentialed Practitioner: _____ MD/NP/PA
Physician/Appropriately Credentialed Practitioner (Print Name): _____ ID Code: _____

TRANSFUSION CONSENT ON REVERSE SIDE - COMPLETE IF INDICATED

If this consent is altered or illegible it must be re-done and re-signed by all parties

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PERMISSION FOR BLOOD TRANSFUSION

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

I will accept Blood/Blood Products ☐ **Yes** ☐ **No**

Restrictions/Limitations _____

1. I authorize New York Presbyterian Hospital and its staff to administer to me, or the named patient, blood transfusion(s)[1] and/or factor concentrate infusion as indicated.

2. In connection with my consent to this procedure, my physician has provided me with information about, and discussed and explained to me the following:

   A. The nature, purpose, and reasonably foreseeable risks and benefits of the transfusion, the alternatives, including autologous and directed donation as well as not performing the transfusion, as well as the reasonably foreseeable risks and benefits of the alternatives.

   B. That a blood transfusion is not always successful and that no guarantee or assurance has been given to me or anyone concerning the results of transfusion, and that I may be subject to ill effects as a result of receiving blood and/or blood products.

   C. That this consent applies to all transfusions I receive during this hospitalization and if I am an outpatient to all transfusions during the course of this treatment.

3. I confirm that I have read (or have had read to me) the above consent and fully understand all information given to me. All my questions have been answered.

Patient/Health Care Agent/Guardian/Relative: _____ (Signature)

_____ (Print Name)

Relationship if other than patient: _____ Date: ____/____/_____ Time: _____ AM/PM

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved

I have discussed the nature, purpose, and the reasonably foreseeable risks and benefits of the transfusion, the alternatives, including autologous and directed donation as well as not performing the procedure, as well as the reasonably foreseeable risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

Physician/Appropriately Credentialed Practitioner: _____ MD/NP/PA

Print Name/ID Code: _____ Date: ____/____/_____ Time: _____ AM/PM

***NOTE:** **The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of eighteen (18) or is otherwise unable to consent.**

* "Blood Transfusion" means the administration of red cell, white cell, platelet, cryoprecipitate and plasma products.