Appendix B

**UNIVERSITY HOSPITAL**
**STATE UNIVERISTY OF NEW YORK**
**HEALTH SCIENCES CENTER**
**AT BROOKLYN**

NAME

MR #

N.S.

SERVICE/DOCTOR

AFFIX LABEL OR COMPLETE

# CONSENT TO DIAGNOSTIC OPERATIVE OR SPECIAL PROCEDURE

Date_____ Time_____ AM PM

Patient_____
(Last Name) (First) (Middle Initial)

Age at Last Birthday_____ (Patients under 18 years of age to complete Supplement For Persons under Age 18 Intending to Consent For Themselves)

1. I hereby give authorization and consent for the performance upon _____
(state "myself" or name of Patient)
of the following operation or procedure _____to be performed by Dr. _____and whomever he/she may designate as his/her assistants.
(Name of Physician)

2. The nature, intended purposes, reasonable risks, consequences and alternative methods of treatment have been explained and discussed with me by Dr. _____ , and I give this permission
(Name of Physician)
with full knowledge and understanding thereof.

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3. I further consent to the administration of anesthesia and acknowledge that the probable anesthesia has been identified to me. The reasonable risks, complications and alternative anesthetics or anesthetic procedures have been explained to me. There are no anesthetics that I have reason to believe are harmful to me except _____ I acknowledge that no guarantee has been given to
(Indicate exception to none)
me about the effects of the anesthetic used. I further consent to the supervision of my anesthesia care by a qualified anesthesiologist.

4. I have been advised of the serious nature of the operation or procedure and have been advised that if I desire a further and more detailed explanation of the foregoing, as well as information about more remote risks or complications of the above listed operation/procedure, such explanation will be given to me.

5. I do not desire any further or additional explanation.

6. I also consent to the performance of procedures in addition to or different from those described above, arising from conditions which are presently unforeseen or believed unlikely, if the above-named doctor or those under his/her direction, in their best professional judgment, consider it necessary or advisable during the course of the operation or procedure. Under no circumstances, however, do I consent to

_____

_____
(State nature and extent of procedure for which consent is not given)

7. I acknowledge that I have received no guarantees about the benefits or results of this operation or procedure.

8. In the interest of medical education, I consent to observers being admitted during this operation, treatment or procedure to the operating room.

9. I consent to the disposal by hospital authorities of any tissues or body parts which may be removed.

10. I consent to the administration of such drugs, infusions, transfusions of blood or blood components, or any other treatment deemed necessary or desirable in the judgment of the above-named doctor or or those acting under his/her direction.

11. I acknowledge that I have read this entire document and that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

Date _____ _____

Signature of patient

If consenting party is other than patient:

_____

(State Relationship to Patient)

Witnesses:

_____ _____

Signature Signature

**PHYSICIAN STATEMENT**

I have discussed the nature and purpose of the above operation. Treatment(s) or procedure, and the associated risks, consequences and available alternatives, with the person signing above, and I am satisfied that he/she understands them.

_____M.D.

Signature of Physician Providing Explanation