Facility: NYC Health+Hospitals - **Kings County**

INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES

Chart No.

Name

Unit

(Patient Imprint Card)

NYC HEALTH+ HOSPITALS

FORM B-1

I hereby permit _____ (Name of Attending Physician[s] or Authorized Health Care Provider[s]) or their Associate Attending Physician[s] of the same service, and other authorized assistants, house staff or other providers, some of whom may be selected and supervised by them to perform the following medical treatment, operation, or procedure (hereafter called the "procedure").

Thrombolysis for Stroke

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure. If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment which is necessary.

I agree to have transfusions of blood and other blood products that may be necessary along with the procedure I am having. The risks, benefits and alternatives have been explained to me and all of my questions have been answered to my satisfaction.

If I refuse to have transfusions I will cross out and initial this section and sign a REFUSAL OF TREATMENT Form C.

I agree to allow this facility to keep, use or properly dispose of, tissue and parts of organs that are removed during this procedure.

		and		**am**
Signature of Patient or Parent/Legal Guardian of Minor Patient	**Date**		**Time**	**pm**

If the patient cannot consent for them self, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

		and		**am**
Signature of Health Care Agent/Legal Guardian (Place a copy of the authorizing document in the medical record)	**Date**		**Time**	**pm**
		and		**am**
Signature and Relation of Surrogate	**Date**		**Time**	**pm**

WITNESS:

I, _____, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient, or an authorized representative, voluntarily sign this form ☐, **OR** consent to treatment telephonically ☐ **. (Check one box.)**

I, _____, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed that the patient is **unable** to sign this form ☐; **OR** that the patient or an authorized representative, **refused** to sign this form ☐. (**Check one box.)**

		and		**am**
Signature and Title of Witness	**Date**		**Time**	**pm**

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)

I have provided an accurate and complete interpretation of an explanation/discussion of this form between the health care provider(s) and the patient or the patient's authorized representative.

		and		**am**
Signature of Interpreter (if present), ID# and Agency Name	**Date**		**Time**	**pm**

Facility: NYC Health+Hospitals - **Kings County**

INFORMED CONSENT PROGRESS NOTE

(The Informed Consent Form HH 100 B-1 on the reverse side must also be completed)

Chart No.

Name

Unit

(Patient Imprint Card)

I explained the risks, benefits, side effects and alternatives of the **Thrombolysis for Stroke** (Identify Procedure) to the above-named patient for treatment of _____ (Identify Diagnosis).

As I explained to the patient, the risks, benefits, side effects, alternatives, intended goals and likelihood of success of the procedure to achieving health care goals (including potential problems with recuperation) include but are not limited to:

Risks and side effects of the proposed care:
Bleeding in the brain or other parts of the body (internal or external), need for blood transfusions, permanent brain injury or herniation, worsening or new stroke, shock, fever, allergic reactions, seizures, other unexpected complications including death.

Benefits: Improvement of the stroke symptoms in about one third of patients when given within 3 hours of stroke onset. Likelihood of benefit decreases with time, but treatment more helpful than harmful up to 4.5 hours after onset.

Alternatives (including their risks, side effects and benefits): Observation with hydration and antithrombotic medications (like aspirin) and other medications that are part of standard stroke management.

Risks related to not receiving the procedure: Loss of the opportunity to possibly improve your neurological outcome.

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

_____ _____ **and** _____ **am**
Signature of Attending Physician or Authorized Health Care Provider **Date** **Time** **pm**

_____
Print Name and License Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING PHYSICIAN'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has consented to the proposed treatment for the patient, the surrogate has signed the consent form.

_____ _____ **and** _____ **am**
Signature of the Attending Physician **Date** **Time** **pm**

_____
Print Name and License Number

* Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent.