



Facility:

NYC Health+Hospitals -  
**Kings County**

**NYC  
HEALTH+  
HOSPITALS**

Chart No.

Name

Unit

*(Patient Imprint Card)*

**INFORMED CONSENT  
PROGRESS NOTE**

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

I explained the risks, benefits, side effects and alternatives of the \_\_\_\_\_ (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:

\_\_\_\_\_

Benefits: \_\_\_\_\_

Alternatives (including their risks, side effects and benefits): \_\_\_\_\_

Risks related to not receiving the procedure: \_\_\_\_\_

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.

\_\_\_\_\_  
Signature of Attending Physician or Authorized Health Care Provider

\_\_\_\_\_ Date

and

\_\_\_\_\_ Time

am  
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.

\_\_\_\_\_  
Signature of the Attending Physician

\_\_\_\_\_ Date

and

\_\_\_\_\_ Time

am  
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.