Facility:

NYC Health+Hospitals -

Kings County

INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES HEALTH+ HOSPITALS

Chart No.

Name

Unit

(Patient Imprint Card)

		FO	RM B-1		
I hereby permit or Authorized Health Care Provider[s]) or their Associate Attending Physicial house staff or other providers, some of whom may be selected and super operation, or procedure (hereafter called the "procedure").			orized assistants,		
Lumbar Puncture					
The procedure has been explained to me and I have been told the reasons of also been explained to me. In addition, I have been told that the procedure of about other possible treatments for my condition and what might happen if no I understand that in addition to the risks described to me about this procedure procedure. I am aware that the practice of medicine and surgery is not an example about the results of this procedure. I have had enough time to discuss my condition and treatment with my health to my satisfaction. I believe I have enough information to make an informed unexpected happens and I need additional or different treatment(s) from the	may not have the result no treatment is received e there are risks that ma cact science, and that I have care providers and all of d decision and I agree	t that I expect. I have d. ay occur with any su have not been given of my questions have to have the procedu	e also been told rgical or medical any guarantees been answered ure. If something		
is necessary. I agree to have transfusions of blood and other blood products that may be r benefits and alternatives have been explained to me and all of my questions		•	aving. The risks,		
If I refuse to have transfusions I will cross out and initial this section are		•	rm 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.					
Tagled to allow the radiity to heap, and of property disperse in, access in a	arto or organio mas and	and	am		
Signature of Patient or Parent/Legal Guardian of Minor Patient	Date	Time			
If the patient cannot consent for them self, the signature of either the health patient, or the patient's surrogate who is consenting to the treatment for the	care agent or legal gua patient, must be obtain	ardian who is acting ned. and	on behalf of the		
Signature of Health Care Agent/Legal Guardian (Place a copy of the authorizing document in the medical record)	Date	Time			
		and	am		
Signature and Relation of Surrogate	Date	Time	pm		
WITNESS: I,, am a staff member who is not the and I have witnessed the patient, or an authorized representative, voluntare telephonically, (Check one box.) I,, am a staff member who is not provider and I have witnessed that the patient is unable to sign this for representative, refused to sign this form (Check one box.)	rily sign this form, o	OR consent to treatron or authorized he patient or an authorical	nent alth care ized		
Signature and Title of Witness	Data	and	am		
Signature and Title of Witness	Date	Time	e pm		
INTERPRETER: (To be signed by the interpreter if the patient required such that the provided an accurate and complete interpretation of an explanation/provider(s) and the patient or the patient's authorized representative.		between the health	care am		
Signature of Interpreter (if present), ID# and Agency Name	Date	and Time			

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)

NYC HEALTH+ HOSPITALS

Chart No.

Name

Unit

(Patient Imprint Card)

I explained the risks, benefits, side effects and alternatives of the			((Identify
Procedure) to the above-named patient for treatment of		(Identify Dia	gnosis).
As I explained to the patient, the risks, benefits, side effects, alternatives, intachieving health care goals (including potential problems with recuperation) Risks and side effects of the proposed care:	tended goals and likelihoo include but are not limite	od of success d to:	of the proce	edure to
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 had opinion that the patient understands what I have explained.	ave answered the questio	ns asked and	it is my profe	essional
Signature of Attending Physician or Authorized Health Care Provider	Data	and	Time	_ am
Signature of Attending Physician of Authorized Health Care Provider	Date		ıme	pm
Print Name and License Number				
IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIEN THE PATIENT LACKS DECISIONAL CAPACITY.	T, THE ATTENDING PH	YSICIAN MU	ST CERTIFY	/ THAT
ATTENDING PHYSICIAN'S CE	ERTIFICATION			
I have examined the above-named patient and it is my professional medical informed health care decisions. I understand that if this patient has appoint the patient's Health Care Proxy must be inserted in the medical record. treatment for the patient, the surrogate has signed the consent form.	ed a health care agent to	make these	decisions, a	copy of
		and		am
Signature of the Attending Physician	Date	<u></u>	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.