SUNY DOWNSTATE Medical Center | University Hospital of Brooklyn

Name	
MR#:	DOB:
N/S:	Service/Doctor:

CONSENT TO SURGICAL, INVASIVE, OR DIAGNOSTIC PROCEDURE

1. I agree to allow ______________________________, who is a
(Certified Practitioner)

(circle one): medical doctor, doctor of osteopathy, nurse practitioner, physician assistant, certified nurse midwife, or certified registered nurse anesthetist, to perform a/an:

Lumbar Puncture
(Procedure, Surgery)

____
(Procedure, Surgery)

on ______________________________.
("Me" or Patient's Name)

2. The procedure/surgery has been explained to me by ____________________.
3. In making my decision to have this procedure/surgery, I understand the risks and the possible benefits. I also understand the possible side effects and possible problems of the healing process.
4. I understand the alternatives to this procedure/surgery and the risks and benefits of the alternatives. I also understand the risks and benefits of not having this procedure/surgery.
5. I understand that the procedure/surgery may not have the result I hope it will have.
6. In agreeing to have this procedure/surgery, I accept the risks, the side effects and the possible problems from the healing process that have been explained to me.
7. I understand that residents may perform important surgical tasks during this procedure/surgery, and that medical students may also be involved, all under the supervision of the attending physician.
8. If something unexpected occurs during this procedure, I agree to treatment that the attending physician or a physician who is brought in by the attending physician thinks is necessary.

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

10. I have had enough time to discuss and think about the planned procedure/ surgery and all of my questions have been answered. I have enough information to make an informed decision. I agree to this procedure/ surgery.

______________________ ______________________ ______________
Patient/Surrogate (print) **Signature** **Relationship**

__________ __________
Date **Time**

WITNESS: ***I have witnessed the patient / surrogate sign this form.***

______________________ ______________________ ______________
Witness's Name (print) **Signature** **Date**

INTERPRETER: ***I have interpreted truthfully and accurately to the best of my ability.***

______________________ ______________________ ______________
Interpreter's Name (print) **Signature** **Date**

CERTIFIED PRACTITIONER'S STATEMENT

I have discussed with the patient/surrogate the relevant potential benefits, risks and side effects, possible problems related to recuperation, likelihood of achieving our goal, as well as the possible results of not having this procedure/surgery. Additionally, I have provided the patient/surrogate with the opportunity to ask questions, and I have answered all questions that were asked. I believe that he/she understands what we have discussed, and that he/she has given an informed consent.

______________________ ______________________ ______________
Practitioner (print) **Signature** **Date**