DT40580

UPSTATE
UNIVERSITY HOSPITAL

CONSENT FOR DIAGNOSTIC, THERAPEUTIC, INVASIVE OR SURGICAL PROCEDURES

Patient Name: _____ MR#: _____

Account #: _____ DOB: _____ Date: _____

1. I give permission to the designated practitioner _____
(Attending Physician or other Practitioner)
and the following physician(s) _____
(Specify Additional Physicians, Excluding Residents)
whom are reasonably anticipated by my doctor to be actually involved in the treatment, procedure or surgery to be performed upon _____ the following procedure or operation:
(state "myself" or name of patient)

_____
(state nature of procedure first in medical terminology then in laymen's terms)

_____

I understand that resident physicians and/or other qualified non-physician practitioners who are not identified above may perform important tasks during the surgery or procedure.

2. I understand and it has been explained to me that at this teaching hospital, health care students are routinely part of the treatment team.
3. Initial only if applicable: _____ I have been informed that a health care student may, for educational purposes, perform a vaginal, rectal or genital examination and I give my permission to such examination.
4. The purpose of and the benefit(s) which may be anticipated from the surgery/procedure(s), although not guaranteed, have been explained to me. The main risks and discomforts which may or will result from the surgery/procedure(s) have been explained to me. The consequences of not having this surgery/procedure have also been explained to me.
5. Alternative surgery/procedures, including the alternative of no treatment, have been explained to me along with the potential benefits and risks.
6. In addition to the benefits and risks which are or may be involved in the surgery/procedure(s), I also know that there is always the possibility of unforeseen or unanticipated conditions occurring. If this occurs, I understand that the medical personnel will use their judgment with respect to my care and treatment, which may involve performing additional or different procedures from those stated, or otherwise altering the planned course of action. This may include the **unanticipated** need for blood transfusion **and the use of x-rays or other diagnostic or therapeutic measures**. I authorize them to do so.
7. If applicable, I give permission for:
   - The use of moderate sedation medicines. These medicines are given to temporarily decrease the sensation of pain, produce calmness, and a sense of well being and/or pain relief.
   - The use of deep sedation medicines. These medicines cause brief unconsciousness and are administered by a non-anesthesiologist physician.

   I understand that if sedative or analgesic medicines are administered, I will need to be monitored until I am fully awake before being discharged. In addition, I will only be discharged in the care of a responsible adult.
8. If applicable, I consent to the administration of anesthesia and the use of such anesthetics and invasive monitoring as may be deemed advisable in the medical judgment of and under the supervision of an anesthesiologist.
9. I give permission for the disposal of and/or release of any tissue removed to be used for scientific purposes after all necessary diagnostic tests have been completed. I understand that all identifying information will be removed.
10. I give permission for my social security number to be used as required by the FDA Safe Medical Device Act.
11. I have a current **Do Not Resuscitate (DNR)** Order in place. (Check the box) ☐Yes ☐No
    If I checked **yes** and have a DNR Order and I am undergoing a procedure requiring moderate sedation and/or services provided by an anesthesiologist.
    a. I wish to maintain DNR status during my operation/procedure. (Check the box) ☐Yes ☐No
       If Yes, Attending Surgeon or designee must initiate physician to physician communication with Attending Anesthesiologist. **OR**
    b. I wish to discontinue DNR status during my operation/procedure. I understand that my DNR status will be resumed when I am discharged by the Anesthesiology Service. (Check the box) ☐Yes ☐No
    c. Not applicable because I am not having moderate sedation or general anesthesia. ☐N/A

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12. For the purpose of medical education, I understand that my condition or the procedure I will have performed is expected by my doctor to be useful for medical education purposes if it is recorded, either through visual and/or audio means, and I have been provided with a full explanation of how it will be recorded and how it will be used, and, I consent to the photography and/or televising audio and/or visual recording of the procedure to be performed provided my identity is not revealed. . . . . ☐Yes ☐No ☐N/A
If I am not being asked at this time to consent to the photography, and/or televising audio and/or visual recording for the purposes of medical education, I understand that if my doctor determines during the procedure that it will be useful, that the recording may be performed at the direction of my doctor but will not be used for any purpose unless I later give my consent, and if I do not give my consent the recording will be immediately destroyed.
13. I consent to the presence of additional non-hospital staff during my surgery as directed by my attending surgeon or anesthesiologist. This may include manufacturer representatives or technicians.
(List names below)
14. I have been provided with a full opportunity to ask any questions or express any concerns I may have. My questions have been answered and my concerns addressed to my satisfaction. I understand that I may ask for further information and it will be given to me.
15. I have read this entire document and understand its contents. In addition, I have been told that I am free to withdraw any portion of my consent.
16. I have either completed or crossed off and initialed any unacceptable statements above prior to my signing.
17. Hospitals must test all patients receiving outpatient elective surgeries and non-urgent procedures for COVID-19 and patients must test negative for COVID-19 using a molecular assay for detection of SARS-CoV-2 RNA prior to any such surgery or procedure. The test must be administered no more than 3 days prior to the surgery or procedure. For the past 14 days I have complied with the guidelines by:
    a. maintaining current social distancing recommendations
    b. following other preventative measures such as wearing a cloth face covering in public when social distancing might not be possible
    c. minimizing trips away from home as much as possible
    d. informing the healthcare provider performing the surgery or procedure if there is any contact with a suspected or confirmed case of COVID-19 or a person with symptoms consistent with COVID-19
    e. informing the healthcare provider of any symptoms consistent with COVID-19 or a positive test result for COVID-19

Date	Time	Signature of Patient	Print Name

If consenting party is other than patient:

Date	Time	Signature of Consenting Party	Relationship to Patient

Consent Form Witness:

Date	Time	Signature of Witness	Print Name

Person Explaining Procedure:

Date	Time	Signature/Title of Attending or other Staff Explaining Procedure	Print Name

Proceduralist Verification for invasive or operative procedures

I verify that the patient has been identified. The consent is accurate, complete and signed. I have marked the operative site if applicable and have reviewed pertinent radiographic images. Any images needed for the procedure are available to me in the OR/procedural area. I have checked that any implants, equipment needed to complete the procedure are available. If this is an operative procedure or if anesthesia is planned, the H&P has been done within 30 days and reviewed within the last 24 hours and updated as necessary and I have written a pre-procedural attending note.

Date	Time	Proceduralist Signature/Title	Print Name

List below all Non University Hospital personnel present in the OR/Procedure Room at the time of surgery/procedure. Inform the patient/patient representative about their presence.

NAME/TITLE	NAME/TITLE