Reset Form

New York Eye and Ear Infirmary of Mount Sinai

# NEW YORK EYE AND EAR INFIRMARY

**Patient Consent Form for Operation or Special Procedure**

PATIENT _____ DATE OF BIRTH _____ CHART # _____

1. Permission. I hereby authorize Doctor _____ (and other such physician(s) or other authorized persons at the Hospital as he/she may designate) to perform upon _____ the following operation(s):
   myself (or name of patient)

   _____
   (please print or type)

2. Unforeseen Conditions. If any unforeseen condition arises in the course of the operation or procedure for which other procedures, in addition to or different from those above contemplated, are necessary or appropriate in the judgment of the said physician or his designee(s), I further request and authorize the carrying out of such operation or procedures.

3. Specimens. Any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with accustomed practice and applicable State laws and regulations.

4. Photographing, Videotaping, etc. I consent to the photographing, videotaping, televising or other observation of the operation or procedures to be performed; including appropriate portions of my body, for medical, scientific or educational purposes; provided my identity is not revealed by the pictures or descriptive texts accompanying them. I also consent to the admission of authorized observers into the operating or treatment room.

5. Explanation of Procedure, Risks, Benefits and Alternatives, The nature and purpose of the operation/procedure, possible alternative methods of treatment, the expected benefits and complications, attendant discomforts and the risks involved have been fully explained to me. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

6. I further consent to the administration of blood or blood products as may be considered necessary. I recognize that there are always risks to health, associated with the administration of blood or blood products and such risks have been fully explained to me.

7. Cornea Transplants. I consent to the release of information to the eye bank that supplied the tissue used for corneal transplant surgery. I understand that for my own health protection it may be necessary for the eye bank to contact me.

8. No Guarantees. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

_____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATION THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE, AND THAT ALL THE BLANK SPACES ABOVE HAVE BEEN COMPLETED PRIOR TO MY SIGNING.

Patient/Relative/Guardian*: _____ Date _____ Time _____

Relationship, if other than patient signed: _____ Date _____ Time _____

Interpreter, if required: _____ Date _____ Time _____

Witness: _____ Date _____ Time _____

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

**PHYSICIAN'S CERTIFICATION**

I hereby certify that I have explained to the patient the nature, purpose, benefits, risks of and alternatives to the procedure/operation, have offered to answer any questions and have fully answered such questions. I believe that the patient [relative/guardian] fully understands what I have explained and answered.

_____ _____ _____ _____

Physician's Signature | Print Physician's Name | Date | Time

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.

(Vea al Reverso)

Web Form