

THE NEW YORK EYE AND EAR INFIRMARY
Patient Consent Form for Operation or Special Procedure

*Web Form

PATIENT

DATE OF BIRTH

CHART #

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

(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. Anesthesia. I consent to the administration of anesthesia under the direction of the Department of Anesthesiology of the New York Eye and Ear Infirmary. I understand that certain risks and complications (including damaged teeth) may result from the administration of anesthesia.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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 _____
9. 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*: _____

Relationship, if other than patient signed:

Interpreter, if required: _____

Witness: _____

Date: _____

* 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