Reset Form

New York Eye and Ear Infirmary of Mount Sinai

Name
DOB
MRN

CONSENT TO SURGERY/PROCEDURE/ TREATMENT AND ANESTHESIA

1. I hereby authorize _____ (*Physician/Provider*) and _____ (*Co-Surgeon/Privileged Proceduralist*) and those associates or assistants designated to perform upon _____ (*Name of Patient or "Me"*) the following treatment(s), surgery(ies), and/or procedure(s) to include:

   _____

   A team of medical professionals will work together to perform my procedure/surgery. My Physician/Provider or Designated Attending will be present for all critical parts of the procedure/surgery, although other medical professionals may perform some aspects of the procedure as my doctor or the Attending Designee deems appropriate.

2. The Attending Physician above (or his/her designee: _____) has fully explained to me, in my preferred language, the nature of the proposed care, treatment, services, interventions, procedures and/or medications and has also informed me of the potential benefits, risks or side effects, including potential problems that might arise during recuperation. I have been informed of the likelihood of achieving the proposed goals and of the reasonable alternatives to the proposed plan of care. I have been informed of the relevant risks, benefits and side effects related to alternatives including the possible results of not receiving the proposed treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
3. I understand that, during the course of the above proposed surgery, treatment, or procedure, unforeseen conditions may arise which necessitate a surgery, treatment, procedure different from those contemplated. I consent to the performance of additional surgery/ treatment/procedure which the above-named physician or his/her associates/assistants may consider necessary.
4. I understand that I may require the administration of anesthetics/sedatives/analgesics deemed necessary under the direction of an authorized provider. I understand that I will be made aware of the risks, benefits of, and alternatives to the administration of anesthetics/sedatives/analgesics prior to the surgery/procedure/treatment by an authorized provider.
5. I further consent to the transfusion of blood or blood components as deemed necessary for the proposed surgery/treatment/ procedure. I have been made aware of the risks, benefits of, and alternatives to the administration of these products.
6. Any organ(s)/tissue(s)/implant(s)/body fluids surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues, organs and/or body fluids may be disposed of in accordance with customary practice.
7. I consent to the photographing, videotaping and/or closed circuit televising, and publication thereof, of this surgery/treatment/ procedure for medical, scientific or educational purposes, provided my identity is not revealed. I also consent to the admission of authorized observers and/or technical or vendor support to the Operating or Treatment Room.
8. I have crossed out and initialed any paragraphs to which I do not consent.

	Print Name	*Signature*	*Time*	*Date*	*Relationship*	
Patient*, Relative or Guardian						
Signature Witness:						Patient Confirmed Signature Witness *(Check box if Applicable)* ☐
Interpreter Name or Number						Patient Refused Interpreter *(Check box if Applicable)* ☐

☐ **Telephone Consent *(Check box if applicable)***

➔ **The Attending Physician or Privileged Proceduralist who is performing the procedure must sign the certification below.**

I, the Attending Physician or Privileged Proceduralist, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/operation have been explained to the patient/relative/guardian and I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

Print Name	*Attending Physician/Privileged Proceduralist Signature*	*Time*	*Date*

➔ **If more than thirty days have passed since this consent form was signed or the consent conversation was held:**

I, the Attending Physician or Privileged Proceduralist, have reaffirmed the patient's understanding and certify that there has been no substantial change to the patient's condition in the time period since the consent form was signed.

Print Name	*Attending Physician/Privileged Proceduralist Signature*	*Time*	*Date*

* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.
NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.