White Plains Hospital

Provide patient name and date of birth for faxing purposes

(Patient Sticker)

Patient Name: _____

Patient Date of Birth: _____

CONSENT FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURES

1. I, the undersigned, do understand and hereby give my consent and authorize my physician/provider _____ at White Plains Hospital to perform upon me the following operation(s)/ procedure(s) and/or course(s) of treatment:

_____

_____

_____

_____

_____

_____

Procedure in lay terms: _____

_____

_____

_____

2. I understand and agree that the following individual(s) may perform some tasks or parts of the procedure.

☐ N/A

☐ Dr.(s) _____

☐ A qualified non-physician (nurse practitioner, certified nurse mid-wife, physician assistant or registered nurse), under the supervision of the above physician(s). **Name:** _____

☐ Another physician, or a qualified non-physician not currently identified, may assist my physician. I consent to this person.

The qualified assistant may perform, but is not limited to:

- Opening and/or closing of the surgical site
- Altering tissues
- Dissecting (cutting) tissue, organ or bone
- Removing tissue, organ or bone
- Inserting a medical device/implants
- Transplanting tissue
- Harvesting of grafts
- Placing an invasive line
- Other (describe) _____

3. My physician has fully explained to me the nature and purpose of the operation(s) / procedure(s) and /or course(s) of treatment and has also informed me of expected benefits and potential complications, including but not limited to, (from known and unknown causes), discomforts and risks that may arise, both during the procedure and the recuperation period, as well as possible alternatives to the proposed treatment, including no treatment. The risks of the alternatives to the proposed treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

4. I understand that during the operation(s)/ procedure(s) and/or course(s) of treatment, an unforeseen condition may arise which necessitates procedures different from those contemplated. I therefore consent to the performance of additional operations and procedures which the above-named physician or his/her associates or assistants or consulting physician may consider necessary.

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5. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation(s)/ procedure(s) and/or course(s) of treatment.
6. I consent to photographing, videotaping, and televising or other observation of the operation(s)/ procedure(s) and/ or courses of treatment as may be useful for the advancement of medical knowledge and/or education.
7. I consent to the presence of medical sales representatives, students or healthcare professionals during the operation(s)/ procedure(s) and/or course(s) of treatment.
8. I consent to my blood being tested for HIV, Hepatitis B and Hepatitis C in the event a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease.
9. By signing below, I confirm that I have read and fully understand the information provided to me, and I give my consent to the operation(s)/ procedure(s) and/or course(s) of treatment specified above. I grant permission for the use of such tissues and /or organs as may be necessary to be removed during the procedure, for the purposes of pathological diagnosis, and thereafter used for the advancement of medical science and education. Tissue and/or organs will be disposed of in accordance with customary practices at this hospital or at such other institution as this Hospital may designate.
10. I have crossed out and initialed any paragraphs or words above that do not pertain to me.

_____	____/____/_____	_____	_____	_____
TIME	DATE	*(Patient/Health Care Agent/Surrogate/ Guardian Printed Name)	(Signature)	(Relationship to Patient)

_____	____/____/_____	_____	_____
TIME	DATE	(Witness Printed Name)	(Signature)

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved. _____ Interpreter ID #

*The signature of the patient must be obtained unless the patient is a minor (under the age of 18), or is unable to give consent or otherwise lacks capacity to consent. Reason: _____

Physician Attestation:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and the attendant risks) to the proposed operation(s)/ procedure(s) and/or courses of treatment. I have offered to answer any questions and have fully answered all such questions. I believe that the Patient/Health Care Agent/ Surrogate/Guardian fully understands what was explained and answered.

_____	____/____/_____	_____	_____
TIME	DATE	(Physician's/Provider's Printed Name)	(Signature)