North Shore LIJ ***Lenox Hill Hospital***
100 East 77th Street, New York, NY 10075-1850
210 East 64th Street, New York, NY 10065-7471

CONSENT TO SURGICAL PROCEDURE, INVASIVE TEST, PROCEDURE, TREATMENT and/or ANESTHESIA

I hereby authorize Dr. Stuart D. Katchis and his/her associates or assistants to perform upon the named patient or me the following surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s): _____
_____
_____
Including such photographing, videotaping, televising or other observation of the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) as may be purposeful for the advancement of medical knowledge and /or education, with the understanding that my/the patient's identity will remain anonymous.

The purpose of the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatments(s) has/have been explained to me and I have also been informed of the expected benefits and possible complications, attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. The attendant risks of no 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.

I understand that during the course of the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) that unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) which the above-named physician or practitioner or his /her associates or assistants may consider necessary.

I consent to the release of my social security number to the manufacturer of any device that is surgically implanted in me during my admission. I understand release of my social security number is for the purpose of helping the manufacturer locate me if there is a need to contact me with regard to the implanted medical device.

I further consent to the administration of blood transfusion(s) during surgery and during the Recovery Room periods as may be considered necessary. I recognize that there are always risks to life and health associated with blood transfusion(s) and such risks have been fully explained to me. The benefits of blood transfusion(s) and alternatives to their use have also been explained to me.

I understand that the use and type of anesthesia, sedatives or analgesics which may be considered necessary will be explained to me by the Anesthesiologist before surgery or by the physician or practitioner administering the medication prior to any surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s). The risks, benefits and alternatives to their use will also be explained to me.

I understand 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 customary practices.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s).

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above, which do not pertain to me.

Patient/Healthcare Agent/Guardian/Next-of-kin: _____
Signature

_____
Print Name Date/Time

Relationship (if signed by other than patient): _____

Witness: _____
Signature Print Name Date/Time

Interpreter: _____
Signature Print Name Date/Time

Physician/Practitioner Certification

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the surgical procedure(s)/invasive test(s)/procedure(s) and /or treatment(s) and blood transfusion(s) have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner _____ Stuart D. Katchis, M.D _____
Signature/Title Print Name Date/Time