Northwell℠
Long Island Jewish Medical Center

Consent To Operative / Invasive / Diagnostic Procedures, Anesthesia / Sedation / Analgesia

1. **Permission.** I authorize Dr. _____ and his/her associates or assistants _____ and possible residents
(NAMES)
and/or fellows at this healthcare facility to perform the following operation(s) and/or diagnostic procedure(s), and/or course of treatment(s): (procedures to be written both in medical terminology and in terms that the patient can understand).

_____

_____

_____

_____

_____

including such photographing, videotaping, televising or other methods of visually and/or audible recording the procedure(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.

2. **Explanation of procedure(s), risks, benefits and alternatives.**
Dr. _____ has fully explained to me the nature and purpose of the operation(s)/procedure(s) and has also informed me of expected benefits and complications (from known causes), attendant discomforts and the risks that may arise, as well as possible alternative methods of diagnosis and/or treatment to the proposed procedure(s), including no treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

3. **Overlapping Surgery:** ☐ Applicable **(COMPLETE QUALIFIED SURGEON INFO BELOW)
My Surgeon has informed me that my surgery is scheduled to overlap with another procedure she/he is scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery but may not be present for my entire surgery. My surgeon has also informed me that she/he will supervise the surgical team which may include another qualified surgeon, a surgery fellow and surgery residents and that some members of the surgical team will perform parts of my surgery. My surgeon or another qualified surgeon will be immediately available should the need arise during my surgery. My surgeon has answered all of my questions about overlapping surgery and I give consent.
**Qualified Surgeon Name: _____
**Qualified Surgeon Contact Information: _____
Patient's Initial: _____ Date: _____ Time: _____

4. **Anesthesia.** I understand that anesthetics, sedatives or analgesics (as may be considered necessary) and the type, will be explained to me along with the risks, benefits and alternatives by a representative of the anesthesia team or other practitioner (with appropriate competencies) providing sedation/anesthesia services at this healthcare facility prior to the surgery.

5. **Blood and Blood Products.** I further consent to the administration of blood or blood products as may be considered necessary unless I initial the refusal below. 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.

I refuse transfusion or packed red cells, platelets, plasma or white blood cells even if such refusal will result in my death. ***Patient's Initial: _____

***Patients refusing blood products must initial this form and complete "Informed Consent for Blood Avoidance, Blood Refusal and Blood Management" form # VD003.**

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6. **Specimens.** Any organ and/or tissue surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such organ and/or tissue may be disposed of in accordance with customary practices and applicable State laws and regulations. Post pathology gross examination and six weeks after final diagnosis, organ and/or tissue may be transported to the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell to be used for medical student training and scientific research purposes or otherwise appropriately disposed of.
7. **Understanding of this form.** I confirm that I have read this form, fully understand its contents, and that all the blank spaces above have been completed prior to my signing. I understand that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) described above.

Patient/Agent/Surrogate/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

Responsible Practitioner's Certification. I certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate. 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 the consent from the patient. If applicable, I certify that outside pathology slides have been reviewed by the Hospital's Pathology Department.

Responsible Practitioner's Signature	Date	Time	
Print Responsible Practitioner's Name			Contact Information

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Reconsideration of DNR Orders For Surgery Or Invasive Procedures

Patients who have a DNR order are given the option to temporarily suspend the order so certain treatments may be used for reversible situations. You may select from the 3 options below and discuss with your provider.

Check One Only:

☐ **OPTION 1 - DNR SUSPENSION: *FULL RESUSCITATION***

The Patient desires full resuscitation measures to be employed during anesthesia/moderate sedation in the Operating / Procedure / Recovery areas regardless of the situation. The DNR order will be re-instituted upon the end of the recovery phase.

☐ **OPTION 2 - DNR MODIFIED: *LIMITED RESUSCITATION***

During anesthesia/moderate sedation in the Operating / Procedure / Recovery areas, the Patient desires attempts to resuscitate only if, in the clinical judgment of the attending anesthesiologist and surgeon or interventionalist, the adverse clinical events are believed to be both temporary and reversible. The DNR order will be re-instituted upon the end of the recovery phase.

Describe Limitations: _____

☐ **OPTION 3 - DNR AFFIRMED: *DO NOT RESUSCITATE***

The Patient desires the DNR directive already in place pre-operatively to remain in effect during all clinical situations including those that may occur while in the Operating / Procedure / Recovery areas, regardless of cause.

Patient/Agent/Surrogate/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
Telephonic Interpreter's ID #	Date	Time		
OR				
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date	Time	Print Witness Name	

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Responsible Practitioner's Signature	Date	Time	
Print Responsible Practitioner's Name			Contact Information