

Facility:

Elmhurst Hospital Center

Chart No.

Name

Unit

(Patient Imprint Card)

**موافقة مستنيرة للقيام بإجراءات باضعة (الشق)
والتشخيص وإجراءات طبية وجراحية
(INFORMED CONSENT FOR INVASIVE,
DIAGNOSTIC, MEDICAL & SURGICAL
PROCEDURES)**

FORM B-1

أعطي بموجب هذه الوثيقة الإذن إلى _____ (اسم الطبيب المعالج أو مقدم الرعاية الصحية المخول / **Name of Attending Physician or Authorized Health Care Provider**) أو شريك / شريكة الطبيب المعالج في نفس الخدمة، والمساعدين كما قد يتم اختيارهم والإشراف عليهم من قبله / قبلها لأداء العلاج الطبي أو العملية أو الإجراء التالي (المسمى من الآن وصاعداً بـ "الإجراء"/ "hereafter called "procedure") : **Cardiac Catheterization/Percutaneous Coronary Intervention, Possible Intra-Aortic balloon pump, possible pacemaker.**

Possible Coronary Artery Bypass Surgery

لقد تم شرح الإجراء لي وأخبرت عن أسباب احتياجي له. كما تم شرح مخاطره عليّ. إضافة إلى هذا، أخبرت بأن الإجراء قد لا يؤدي إلى النتيجة التي أتوقعها؛ كما تم إفادتي عن علاجات ممكنة أخرى لحالتي وماذا الذي قد يحدث لي إذا لم أتلق العلاج. إضافة إلى المخاطر المبينة لي عن هذا الإجراء، فأنا أفهم أن هناك مخاطر قد تحدث في أي إجراء جراحي أو طبي. وأدرك أن ممارسة الطب والجراحة ليست بعلم دقيق، وأنه لم يقدم لي أي ضمانات حول نتائج هذا الإجراء. وقد أتيت لي الوقت الكافي لبحث حالتي وعلاجي مع مقدمي الرعاية الصحية المسؤولين عني وقد تمت الإجابة على جميع أسئلتني بشكل مرض لي. وأني أعتقد أنه لدي معلومات كافية لاتخاذ قراراً مستنيراً وأوافق على أن أجري الإجراء عليّ. وفي حال حدوث شيء غير متوقع به وإذا تطلب الأمر إلى علاج إضافي أو مختلف (أو علاجات إضافية أو مختلفة) عن العلاج الذي أتوقعه، فأني أوافق على قبول أي علاج قد يلزم الأمر إليه. وأوافق على قبول نقل الدم وأي من مكوناته التي قد تكون لازمة طوال الإجراء الذي سيجرى عليّ. لقد تم شرح المخاطر والمنافع والبدائل لي وتمت الإجابة على جميع أسئلتني بشكل مرض لي. إذا قررت رفض قبول نقل الدم، سألقوم بشطب هذا القسم وتوقيع الحروف الأولى من اسمي وأوقع على نموذج رفض العلاج. وأوافق على أن أسمح لهذه المنشأة أن تحتفظ بالأنسجة وأجزاء من الأعضاء التي يتم إزالتها خلال الإجراء أو استخدامها أو التخلص منها حسب الأصول.

صباحاً (am)
مساءً (pm)

و
الساعة (Time)
(and)
التاريخ (Date)

توقيع المريض (ة) أو والد / ولي الأمر الشرعي للمريض (ة) القاصر (ة)
(Signature of Patient or Parent/Legal Guardian of Minor Patient)

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

صباحاً (am)
مساءً (pm)

و
الساعة (Time)
(and)
التاريخ (Date)

توقيع ممثل المريض (ة) لشؤون الرعاية الصحية / ولي أمر المريض (ة)
(Signature of Health Care Agent/Legal Guardian)
(Place a copy of the authorizing document in the medical record)

صباحاً (am)
مساءً (pm)

و
الساعة (Time)
(and)
التاريخ (Date)

توقيع الشخص البديل وصلة القرابة بالمريض (ة)
(Signature and Relation of Surrogate)

الشاهد (WITNESS):

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

صباحاً (am)
مساءً (pm)

و
الساعة (Time)
(and)
التاريخ (Date)

توقيع ومسمى وظيفته الشاهد (Signature and Title of Witness)

المترجم الشفهي / المترجم التحريري (INTERPRETER/TRANSLATOR):

(To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

صباحاً (am)
مساءً (pm)

و
الساعة (Time)
(and)
التاريخ (Date)

توقيع المترجم الشفهي / المترجم التحريري (Signature of Interpreter/Translator)

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**INFORMED CONSENT
PROGRESS NOTE**

**(The Informed Consent Form HHC 100 B-1
on the reverse side must also be completed)**

I explained the risks, benefits, side effects and alternatives of the cardiac catheterization/primary coronary angioplasty (Identify Procedure) to the above-named patient for treatment of _____ (Identify Diagnosis).

As I explained to the patient, the risks, benefits, side effects, alternatives, intended goals and likelihood of success of the procedure to achieving health care goals (including potential problems with recuperation) include but are not limited to:

Risks and side effects of the proposed care: **Bleeding from access site, vascular injury, allergic reaction to contrast, heart attack, kidney failure, stroke, serious arrhythmia, rarely death. I understand that a possible outcome of angioplasty is the need for emergency cardiothoracic(bypass) surgery and that this service is not available on site at Elmhurst Hospital. Should I require bypass surgery, I will be transferred to Mount Sinai Hospital for this service.**

Benefits: Definitive Diagnosis of Coronary Artery Disease/Treatment of blocked coronary artery

Alternatives (including risks, side effects and benefits): _____

Risks related to not receiving the procedure: _____

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider*

_____ and _____ am
Date Time pm

Print Name and Identification Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING PHYSICIAN'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has consented to the proposed treatment for the patient, the surrogate has signed the consent form.

Signature of the Attending Physician

_____ and _____ am
Date Time pm

Print Name and Identification Number

* Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent. See also HHC Consent Policy, Article III.

Facility: **Elmhurst Hospital Center**



Chart No.

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**موافقة مستنيرة بشأن التخدير و/أو التسكين
(INFORMED CONSENT FOR
ANESTHESIA
AND/OR SEDATION ANALGESIA)**

FORM B-2

أعطي بموجب هذه الوثيقة الإذن إلى _____ (اسم الطبيب المعالج أو مقدم الرعاية الصحية المخول / Name of / **Attending Physician or Authorized Health Care Provider**) أو شريك / شريكة الطبيب المعالج في نفس الخدمة، والمساعدين كما قد يتم اختيارهم والإشراف عليهم من قبله / قبلها لإعطاء:

Sedation Analgesia / التسكين

Anesthesia / التخدير

لقد تم إفاذتي بشأن مخاطر ومنافع وبدائل إعطاء مثل هذا التخدير و/أو التسكين وتمت الإجابة على أسئلتني بشكل مرض لي.

و _____
صباحاً (am) _____
مساءً (pm) _____
الساعة (Time)
(and)
التاريخ (Date)

توقيع المريض (ة) أو والد / ولي الأمر الشرعي للمريض (ة) القاصر (ة)
(Signature of Patient or Parent/Legal Guardian of Minor Patient)

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

و _____
صباحاً (am) _____
مساءً (pm) _____
الساعة (Time)
(and)
التاريخ (Date)

توقيع ممثل المريض (ة) لشؤون الرعاية الصحية / ولي أمر المريض (ة)
(Signature of Health Care Agent/Legal Guardian)
(Place a copy of the authorizing document in the medical record)

و _____
صباحاً (am) _____
مساءً (pm) _____
الساعة (Time)
(and)
التاريخ (Date)

توقيع للشخص البديل وصلة القرابة بالمريض (ة)
(Signature and Relation of Surrogate)

الشاهد (WITNESS):

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

و _____
صباحاً (am) _____
مساءً (pm) _____
الساعة (Time)
(and)
التاريخ (Date)

توقيع ومسمى وظيفة الشاهد (Signature and Title of Witness)

المرجم الشفهي / المترجم التحريري (INTERPRETER/TRANSLATOR):

(To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

و _____
صباحاً (am) _____
مساءً (pm) _____
الساعة (Time)
(and)
التاريخ (Date)

توقيع المترجم الشفهي / المترجم التحريري (Signature of Interpreter/Translator)

Facility:

Elmhurst Hospital Center



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**INFORMED CONSENT
PROGRESS NOTE**

**(The Informed Consent Form HHC 100 B-2
on the reverse side must also be completed)**

I explained the risks, benefits, side effects and options of the proposed anesthesia and/or sedation analgesia to the above-named patient.

As I explained to the patient, the risks, benefits, side effects, alternatives and intended goals of the anesthesia and/or sedation analgesia (including potential problems with recuperation) include but are not limited to:

Risks and Side Effects:

Cardiac Arrest, Respiratory Arrest, Allergic Reactions,

Pneumonia due to Aspiration

Benefits:

Reduced Pain and Anxiety, Easily Reversible

Alternatives to Anesthesia and/or sedation analgesia (including the risks, side effects and benefits thereof):

No Sedation

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider*

_____ and _____ am
Date Time pm

Print Name and Identification Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING ANESTHESIOLOGIST'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has consented to the proposed treatment for the patient, the surrogate has signed the consent form.

Signature of the Attending Anesthesiologist

_____ and _____ am
Date Time pm

Print Name and Identification Number

* Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent. See also HHC Consent Policy, Article III.

ELMHURST HOSPITAL CENTER
79-01 Broadway, Elmhurst NY 11373

**PRE-PROCEDURE
NOTE / HISTORY & PHYSICAL EXAMINATION**

Present History: _____

Past Medical and Surgical History: _____

Co morbidity: HTN ASHD DM Asthma COPD Other _____

Personal/Social History: Smoking Alcohol Drugs Other _____

Family History Cancer Heart Disease Other _____

Medications: _____ See Medication Reconciliation Record

Allergies: Medications _____ Dye Shellfish Previous Anaphylaxis Other: _____

Review of Systems _____

Physical Exam: Vital Signs: BP _____ HR _____ Resp. _____ Febrile/Afebrile _____

HEENT: _____

Neurological: _____

Lung: _____

Heart: _____

Breast: _____

Abdomen: _____

GU/GYN: _____

Rectal: _____

Extremities: _____

Lab results/date if applicable _____

Diagnosis: _____

Planned Procedure: _____

Privileged Provider Signature Print Name Date Time

Attending Signature Print Name Date Time

IMMEDIATE PRE-PROCEDURE REASSESSMENT EXAMINATION				
I have reviewed the above evaluation. I have re-evaluated the patient immediately prior to the procedure, and I have found:				
<input type="checkbox"/> No significant interval change in his/her condition <input type="checkbox"/> Significant change which I have documented in the Medical Record.				
Name:	ID #:	Signature:	Date:	Time:

**ELMHURST HOSPITAL CENTER
DIVISION OF CARDIOLOGY**

POST-CATHETERIZATION NOTE

Procedure done: _____

Procedure: Manual compression of arterial/venous access site applied for 20 minutes

Vascular closure device deployed successfully/unsuccessfully

Angioseal _____ Other _____

Fem-stop applied for _____ minutes

Physical examination: Present Absent

Bleeding

Hematoma

Vital signs: BP = _____ HR = _____ RR = _____ Cardiac Rhythm = _____

Complication: _____

Comments: _____

Disposition: _____

Cardiology Fellow Signature

Print Name:

Date

Time

If STEMI, reason(s) for PCI delayed:

Consent, e.g. patient wishes to speak with family/clergy prior to consent

Consultation required prior to procedure, e.g. neurology assessment-re bleeding risk/CVA

Additional procedure(s) required, e.g. CT, echocardiogram, pacemaker, IABP

Management, e.g. requires intubation, tx for hemodynamic/electrical instability, stabilizing before transport to catheterization lab

Alternate diagnosis on presentation, e.g. symptoms not consistent on presentation with STEMI

Procedure related, e.g. access issues secondary to PVD, difficult anatomy, unable to cross lesion, anomalous coronaries, previous CABG

Other: please explain

Comment (mandatory): _____

Attending Signature

Print Name

Date

Time