Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(Patient Imprint Card)

侵入式、诊断性、医疗及外科程序知情同意书
(INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES)

FORM B-1

我特此准许 _____ (主诊医生或获授权的医疗保健提供者的姓名/Name of Attending Physician or Authorized Health Care Provider) 或由其选择并监督的同科室副主诊医生和助理，施行以下医疗、手术或程序(下文简称 "医疗程序" / hereafter called the "procedure"): **Cardiac Catheterization/Percutaneous Coronary Intervention,**

Possible Intra-Aortic balloon pump, possible pacemaker. Possible Coronary Artery Bypass Surgery.

院方已向我解释了该医疗程序，并告诉我为什么需要该医疗程序的原因。院方还向我解释了该医疗程序的风险。此外，院方告诉我，该医疗程序可能无法取得我所预期的结果。院方还告诉我治疗我这种疾病的其它手段，以及不治疗可能会有什么后果。

我理解，有关该医疗程序，除了已经向我描述的风险外，还有任何手术或程序都可能发生的风险。我知道，医药和手术并非精密科学，且院方没有对该医疗程序的结果做过任何保证。

我已有足够的时间与我的医疗保健提供者讨论我的病情和治疗手段，并且我所提出的所有问题均已得到满意解答。我认为，我所获得的信息足以令我做出知情的决定，我同意接受该程序。如果发生意外情况，并且在我的预期治疗之外，我还需要额外的或不同的治疗，我同意接受任何必需的治疗。

我同意，必要时，可以在我目前的医疗程序中输送血液和其它血液产品。院方已向我解释了风险、好处及替代方案，且我的所有问题均已得到满意解答。

如果我拒绝输血，我将删去这个部份，写上姓名缩写，并在拒绝治疗表上签字。

我同意此医院保留、使用或妥善处置在此医疗程序中取下的组织及部份器官。

_____	_____ 和 _____	上午 (am)
患者或未成年患者的家长/法定监护人签字 **(Signature of Patient or Parent/Legal Guardian of Minor Patient)**	**日期 (Date)** **(and)** **时间 (Time)**	**下午 (pm)**

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.

_____	_____ 和 _____	上午 (am)
医疗保健代理人/法定监护人签字 **(Signature of Health Care Agent/Legal Guardian)** (Place a copy of the authorizing document in the medical record)	**日期 (Date)** **(and)** **时间 (Time)**	**下午 (pm)**
_____	_____ 和 _____	上午 (am)
代理人的签名及其关系 **(Signature and Relation of Surrogate)**	**日期 (Date)** **(and)** **时间 (Time)**	**下午 (pm)**

证人 (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.

_____	_____ 和 _____	上午 (am)
证人签字和职称 (Signature and Title of Witness)	**日期 (Date)** **(and)** **时间 (Time)**	**下午 (pm)**

口译/笔译员 (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.

_____	_____ 和 _____	上午 (am)
口译/笔译员签字 (Signature of Interpreter/Translator)	**日期 (Date)** **(and)** **时间 (Time)**	**下午 (pm)**

Facility: **Elmhurst Hospital Center**

Chart No.

Name

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(Patient Imprint Card)

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 their 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* _____ **Date** _____ **and Time** _____ **am 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 _____ **Date** _____ **and Time** _____ **am 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.

Name

Unit

(Patient Imprint Card)

麻醉和/或镇定麻醉知情同意书
(INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA)

FORM B-2

我特此准许 _____ (主诊医生或获授权的医疗保健提供者的姓名/ Name of Attending Physician or Authorized Health Care Provider) 或由其选择并监督的副主诊医生和助理施行：

☐ 麻醉 / (Anesthesia)　　☑ 镇定麻醉 / (Sedation Analgesia)

院方已向我解释施行此类麻醉和/或镇定麻醉的风险、好处及替代方案，并且我的问题已经得到满意解答。

_____ _____ 和 _____ 上午 (am) 下午 (pm)

患者或未成年患者的家长/法定监护人签字 (Signature of Patient or Parent/Legal Guardian of Minor Patient)　日期 (Date)　(and)　时间 (Time)

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.

_____ _____ 和 _____ 上午 (am) 下午 (pm)

医疗保健代理人/法定监护人签字 (Signature of Health Care Agent/Legal Guardian)　日期 (Date)　(and)　时间 (Time)

(Place a copy of the authorizing document in the medical record)

_____ _____ 和 _____ 上午 (am) 下午 (pm)

代理人的签名及其关系 (Signature and Relation of Surrogate)　日期 (Date)　(and)　时间 (Time)

证人 (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.

_____ _____ 和 _____ 上午 (am) 下午 (pm)

证人签字和职称 (Signature and Title of Witness)　日期 (Date)　(and)　时间 (Time)

口译/笔译员 (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.

_____ _____ 和 _____ 上午 (am) 下午 (pm)

口译/笔译员签字 (Signature of Interpreter/Translator)　日期 (Date)　(and)　时间 (Time)

Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(Patient Imprint Card)

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* _____ **Date** _____ **and** _____ **Time** **am** **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 _____ **Date** _____ **and** _____ **Time** **am** **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:
☐ No significant interval change in his/her condition ☐ 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