Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(Patient Imprint Card)

आक्रामक, नैदानिक, चिकित्सीय और शल्यक्रियात्मक प्रक्रियाओं के लिए सूचित सहमति
(INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES)

FORM B-1

मैं एतद्वारा _____ को (उपचार करने वाले चिकित्सक या प्राधिकृत स्वास्थ्य देखभाल प्रदाता का नाम / **Name of Attending Physician or Authorized Health Care Provider**) या उसी सेवा के उनके/उसके उपचार करने वाले सहयोगी चिकित्सक, सहयोगियों और सहायकों को जिन्हें उनके द्वारा चुना और पर्यवेक्षित किया जाए, निम्नलिखित चिकित्सा उपचार, ऑपरेशन, या प्रक्रिया (जिसे इसके बाद "प्रक्रिया" कहा गया है) करने की अनुमति देता/देती हूँ / **(hereafter called the "procedure"): Cardiac Catheterization/Percutaneous Coronary Intervention, Possible Intra-Aortic balloon pump, possible pacemaker. Possible Coronary Artery Bypass Surgery.**

मुझे यह प्रक्रिया समझा दी गयी है और मुझे वे कारण बताए गए हैं कि मुझे इस प्रक्रिया की जरूरत क्यों है। मुझे इस प्रक्रिया के जोखिम भी समझा दिए गए हैं। इसके अलावा, मुझे यह भी बता दिया गया है कि हो सकता है इस प्रक्रिया का परिणाम मेरी अपेक्षा के अनुरूप न हो। मुझे मेरी दशा के लिए अन्य संभव उपचार भी बता दिए गए हैं और यह भी कि यदि कोई उपचार न कराया जाए तो क्या हो सकता है।

मैं समझता/समझती हूँ कि इस प्रक्रिया के बारे में मुझे बताए गए जोखिमों के अलावा, ऐसे भी जोखिम हैं जो किसी शल्यक्रिया या चिकित्सा प्रक्रिया के साथ घटित हो सकते हैं। मुझे मालूम है कि दवा और शल्यक्रिया का अभ्यास सटीक विज्ञान नहीं है और मुझे इस प्रक्रिया के परिणामों के बारे में कोई गारंटी नहीं दी गयी है।

मुझे मेरे स्वास्थ्य देखभाल प्रदाता से मेरी दशा और उपचार के बारे में चर्चा करने का पर्याप्त समय मिला है और मुझे मेरे सभी प्रश्नों के उत्तर मेरी सन्तुष्टि के अनुरूप दे दिए गए हैं। मेरा विश्वास है कि सूचित निर्णय करने के लिए मेरे पास पर्याप्त सूचनाएं हैं और मैं यह प्रक्रिया कराने के लिए सहमत हूँ। यदि कुछ अप्रत्याशित घटित होता है और मुझे मेरे द्वारा अपेक्षित उपचार के अतिरिक्त या उससे भिन्न उपचार (रों) की जरूरत होती है तो मैं कोई भी उपलब्ध उपचार, जो आवश्यक हो, स्वीकार करने को तैयार हूँ।

मैं रक्ताधान तथा अन्य रक्त उत्पाद, जो मेरे द्वारा करायी जा रही प्रक्रिया के लिए जरूरी हो सकते हैं, स्वीकार करने के लिए तैयार हूँ। मुझे जोखिम, लाभ और विकल्प समझा दिए गए हैं और मुझे मेरे सभी प्रश्नों के उत्तर मेरी सन्तुष्टि के अनुरूप दे दिए गए हैं।

यदि मैं रक्ताधान कराने से मना करता/करती हूँ तो मैं इस खंड को काट कर उस पर अपस्ताक्षर करूंगी और उपचार से इंकार फार्म पर हस्ताक्षर करूंगा/करूंगी।

मैं इस सुविधाकेंद्र को प्रक्रिया के दौरान हटाए गए ऊतकों और अंगों के हिस्सों को रखने, प्रयोग करने या समुचित रूप से निस्तारित करने की अनुमति देता/देती हूँ।

रोगी या नाबालिग रोगी के माता-पिता/कानूनी अभिभावक के हस्ताक्षर (Signature of Patient or Parent/Legal Guardian of Minor Patient)	**तारीख (Date)**	**और (and)**	**समय (Time)**	**सुबह (am) शाम (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.

रोगी या माता-पिता/कानूनी अभिभावक के हस्ताक्षर (Signature of Health Care Agent/Legal Guardian) (Place a copy of the authorizing document in the medical record)	**तारीख (Date)**	**और (and)**	**समय (Time)**	**सुबह (am) शाम (pm)**
प्रतिनिधि के हस्ताक्षर और रिश्ता (Signature and Relation of Surrogate)	**तारीख (Date)**	**और (and)**	**समय (Time)**	**सुबह (am) शाम (pm)**

गवाह (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.

गवाह का हस्ताक्षर और पद (Signature and Title of Witness)	**तारीख (Date)**	**और (and)**	**समय (Time)**	**सुबह (am) शाम (pm)**

दुभाषिया/अनुवादक (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.

दुभाषिए/अनुवादक के हस्ताक्षर (Signature of Interpreter/Translator)	**तारीख (Date)**	**और (and)**	**समय (Time)**	**सुबह (am) शाम (pm)**

Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(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 (their risks, side effects and benefits): _____

Risks related to 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)

संवेदनाहारी/और या प्रशामक पीड़ा शून्यता के लिए सूचित सहमति
(INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA)

FORM B-2

मैं एतद्वारा _____ को (उपचार करने वाले चिकित्सक या प्राधिकृत स्वास्थ्य देखभाल प्रदाता का नाम / **Name of Attending Physician or Authorized Health Care Provider**) या उनके/उनके सहयोगियों और सहायकों को जिन्हें उनके द्वारा चुना और पर्यवेक्षण किया जाए, को प्राधिकृत करता/करती हूँ:

☐ संवेदनाहारी / **Anesthesia** ☑ प्रशामक पीड़ा शून्यता / **Sedation Analgesia**

मुझे ऐसे संवेदनाहारी/और या प्रशामक पीड़ा शून्यता देने के जोखिम, लाभ और विकल्प समझा दिए गए हैं और मुझे मेरे प्रश्नों के उत्तर मेरी सन्तुष्टि के अनुरूप दे दिए गए हैं।

_____	_____ और _____	सुबह (am)
रोगी या नाबालिग रोगी के माता-पिता/कानूनी अभिभावक के हस्ताक्षर (Signature of Patient or Parent/Legal Guardian of Minor Patient)	तारीख (Date) (and) समय (Time)	शाम (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.

_____	_____ और _____	सुबह (am)
रोगी या माता-पिता/कानूनी अभिभावक के हस्ताक्षर (Signature of Health Care Agent/Legal Guardian) (Place a copy of the authorizing document in the medical record)	तारीख (Date) (and) समय (Time)	शाम (pm)

_____	_____ और _____	सुबह (am)
प्रतिनिधि के हस्ताक्षर और रिश्ता (Signature and Relation of Surrogate)	तारीख (Date) (and) समय (Time)	शाम (pm)

गवाह (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.

_____	_____ और _____	सुबह (am)
गवाह का हस्ताक्षर और पद (Signature and Title of Witness)	तारीख (Date) (and) समय (Time)	शाम (pm)

दुभाषिया/अनुवादक (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.

_____	_____ और _____	सुबह (am)
दुभाषिए/अनुवादक के हस्ताक्षर (Signature of Interpreter/Translator)	तारीख (Date) (and) समय (Time)	शाम (pm)

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