Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(Patient Imprint Card)

침습적, 진단적, 의학적 및 외과적 처치에 대한 정보에 입각한 동의서
(INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES)

FORM B-1

저는 이로써 _____(참가 의사 또는 승인된 의료 서비스 제공자/**Name of Attending Physician or Authorized Health Care Provider**) 또는 동일한 서비스를 제공하는 위 사람의 동료 참가 의사 및 위 사람이 선택하고 감독할 수 있는 조수가 다음 의학적 치료, 수술, 또는 처치(이하 "처치"라고 칭함/ **hereafter called the "procedure"**)를 수행하는 것을 허가합니다: **Cardiac Catheterization/Percutaneous Coronary Intervention, Possible Intra-Aortic balloon pump, possible pacemaker. Possible Coronary Artery Bypass Surgery.**

저는 처치에 대한 설명을 들었으며, 왜 저에게 이 처치가 필요한지 그 이유를 들었습니다. 저는 처치의 위험에 대한 설명도 들었습니다. 또한, 처치로 인해 제가 기대하는 결과가 생기지 않을 수도 있다는 것도 들었습니다. 제 증상에 대한 다른 가능한 치료에 대해, 그리고 아무런 치료도 받지 않으면 어떻게 될 수 있는지에 대해서도 들었습니다.

저는 이 처치에 대해 저에게 설명된 위험과 더불어 모든 외과적 또는 의학적 처치 시 발생할 수 있는 위험이 있음을 이해합니다. 저는 약품 및 수술이 정확한 과학이 아니며, 이 처치의 결과에 대해 아무런 보증도 제공되지 않았음을 알고 있습니다.

저는 제 의료 서비스 제공자와 제 증상 및 치료에 대해 충분한 시간을 갖고 토론하였으며, 제 모든 질문들에 대해 만족스러운 답변을 들었습니다. 저는 정보에 입각한 결정을 내리기에 충분한 정보를 받았다고 생각하며, 저는 그 처치를 받는데 동의합니다. 예기치 못한 일이 발생하여 추가 치료나 제가 기대하는 치료와 다른 치료(들)이 필요한 경우, 필요한 모든 치료를 받아들일 것에 동의합니다.

저는 제가 받게 될 처치와 함께 필요할 수 있는 수혈 및 기타 혈액 제품을 받을 것에 동의합니다. 저는 위험, 혜택 및 대안에 대한 설명을 들었으며, 제 모든 질문들에 대해 만족스러운 답변을 들었습니다.

제가 수혈 받기를 거부하는 경우, 원래의 이 섹션에 줄을 그어 지우고, 치료 거부서 양식에 서명할 것입니다.

저는 이 시설이 이 처치 중에 제거된 조직 및 장기 부분들을 보관하거나 사용하거나 적절하게 폐기할 수 있다는 것에 동의합니다.

_____	_____	및	_____	오전 (am)
환자 또는 미성년자 환자의 부모/법적 후견인 서명	**날짜**	**(and)**	**시간**	**오후 (pm)**
(Signature of Patient or Parent/Legal Guardian of Minor Patient)	**(Date)**		**(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.

_____	_____	및	_____	오전 (am)
의료 대행인/법적 후견인 서명	**날짜**	**(and)**	**시간**	**오후 (pm)**
(Signature of Health Care Agent/Legal Guardian)	**(Date)**		**(Time)**	
(Place a copy of the authorizing document in the medical record)				
_____	_____	및	_____	오전 (am)
대리인 서명 및 관계	**날짜**	**(and)**	**시간**	**오후 (pm)**
(Signature and Relation of Surrogate)	**(Date)**		**(Time)**	

증인 (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.

_____	_____	및	_____	오전 (am)
증인 서명 및 직함 (Signature and Title of Witness)	**날짜**	**(and)**	**시간**	**오후 (pm)**
	(Date)		**(Time)**	

통역자/번역자 (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.

_____	_____	및	_____	오전 (am)
통역자/번역자 서명 (Signature of Interpreter/Translator)	**날짜**	**(and)**	**시간**	**오후 (pm)**
	(Date)		**(Time)**	

Facility: **Elmhurst Hospital Center**

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

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 (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.

_____ _____ and _____ am pm

Signature of Attending Physician or Authorized Health Care Provider* **Date** **Time**

_____

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.

_____ _____ and _____ am pm

Signature of the Attending Physician **Date** **Time**

_____

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)

마취 및/또는 진정 진통에 대한 정보에 입각한 동의서 (INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA)

FORM B-2

저는 이로써 _____(참가 의사 또는 승인된 의료 서비스 제공자/**Name of Attending Physician or Authorized Health Care Provider**) 또는 위 사람의 동료 참가 의사 및 위 사람이 선택하고 감독할 수 있는 조수가 다음을 투여하는 것을 승인합니다:

☐ 마취제/**Anesthesia** ☑ 진정 진통제/**Sedation Analgesia**

저는 그러한 마취제 및/또는 진정 진통제 투여의 위험, 혜택 및 대안에 대한 정보를 받았으며, 제 모든 질문들에 대해 만족스러운 답변을 들었습니다.

_____	_____	및	_____	오전 (am)
환자 또는 미성년자 환자의 부모/법적 후견인 서명	**날짜**	**(and)**	**시간**	**오후 (pm)**
(Signature of Patient or Parent/Legal Guardian of Minor Patient)	**(Date)**		**(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.

_____	_____	및	_____	오전 (am)
의료 대행인/법적 후견인 서명	**날짜**	**(and)**	**시간**	**오후 (pm)**
(Signature of Health Care Agent/Legal Guardian)	**(Date)**		**(Time)**	
(Place a copy of the authorizing document in the medical record)				
_____	_____	및	_____	오전 (am)
대리인 서명 및 관계	**날짜**	**(and)**	**시간**	**오후 (pm)**
(Signature and Relation of Surrogate)	**(Date)**		**(Time)**	

증인 (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.

_____	_____	및	_____	오전 (am)
증인 서명 및 직함 (Signature and Title of Witness)	**날짜**	**(and)**	**시간**	**오후 (pm)**
	(Date)		**(Time)**	

통역자/번역자 (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.

_____	_____	및	_____	오전 (am)
통역자/번역자 서명 (Signature of Interpreter/Translator)	**날짜**	**(and)**	**시간**	**오후 (pm)**
	(Date)		**(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 Reaction**

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