Facility: **Elmhurst Hospital Center**

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

Chart No.

Name

Unit

(Patient Imprint Card)

ŚWIADOMA ZGODA NA ZABIEGI INWAZYJNE, DIAGNOSTYCZNE, MEDYCZNE I CHIRURGICZNE
(INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES)

FORM B-1

Niniejszym zgadzam się, aby _____ (imię i nazwisko lekarza prowadzącego lub upoważnionego świadczeniodawcy opieki zdrowotnej/ **Name of Attending Physician or Authorized Health Care Provider**) lub jego/jej lekarz asystujący świadczący tę samą usługę oraz asystenci wybrani i nadzorowani przez lekarza wykonali następującą terapię medyczną, operację lub zabieg (dalej nazywane "zabiegiem"/ **hereafter called the "procedure"**):
Cardiac Catheterization/Percutaneous Coronary Intervention, Possible Intra-Aortic balloon pump, possible pacemaker. Possible Coronary Artery Bypass Surgery.

Wyjaśniono mi charakter zabiegu i poinformowano, dlaczego jest on konieczny. Wyjaśniono mi zagrożenia związane z zabiegiem. Ponadto poinformowano mnie, że zabieg może nie przynieść oczekiwanych wyników. Poinformowano mnie również o innych terapiach, które można zastosować w moim przypadku, a także o tym co się może stać, jeśli nie otrzymam leczenia.

Przyjmuję do wiadomości, że oprócz przedstawionych mi czynników ryzyka związanych z tym zabiegiem, istnieją inne zagrożenia, które mogą wystąpić przy wszelkich zabiegach chirurgicznych i lekarskich. Mam świadomość, że praktyka medyczna i chirurgiczna nie jest wiedzą ścisłą oraz że nie otrzymałem żadnej gwarancji co do wyników zabiegu.

Miałem wystarczająco dużo czasu, aby omówić stan mojego zdrowia i sposób leczenia z moimi świadczeniodawcami opieki zdrowotnej oraz otrzymałem zadowalające odpowiedzi na wszystkie moje pytania. Wierzę, że mam informacje wystarczające do podjęcia świadomej decyzji i wyrażenia zgody na zabieg. W przypadku, gdy wydarzy się coś nieoczekiwanego i będę potrzebował dodatkowego lub innego leczenia niż planowane leczenie, zgadzam się na takie leczenie, jeśli będzie ono konieczne.

Zgadzam się na transfuzje krwi i innych produktów krwiopochodnych, które mogą być konieczne podczas przeprowadzanego zabiegu. Wyjaśniono mi zagrożenia, korzyści i alternatywy dotyczące zabiegu i uzyskałem zadowalające odpowiedzi na wszystkie moje pytania.

Jeśli nie zgodzę się na przeprowadzenie transfuzji krwi, przekreślę i podpiszę inicjałami tę część formularza i podpiszę formularz ODMOWY LECZENIA.

Zgadzam się, aby placówka ta zatrzymała, wykorzystała lub odpowiednio zutylizowała tkanki lub części organów, usunięte w czasie zabiegu.

_____ _____ i _____ am pm

Podpis pacjenta lub rodzica/opiekuna prawnego w przypadku pacjenta nieletniego (Signature of Patient or Parent/Legal Guardian of Minor Patient) | **Data (Date)** | **(and)** | **Godzina (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.

_____ _____ i _____ am pm

Podpis przedstawiciela służby zdrowia lub opiekuna prawnego (Signature of Health Care Agent/Legal Guardian)
(Place a copy of the authorizing document in the medical record)

_____ _____ i _____ am pm

Podpis i określenie charakteru związku zastępcy (Signature and Relation of Surrogate) | **Data (Date)** | **(and)** | **Godzina (Time)**

ŚWIADEK (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.

_____ _____ i _____ am pm

Podpis i tytuł świadka (Signature and Title of Witness) | **Data (Date)** | **(and)** | **Godzina (Time)**

TŁUMACZ (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.

_____ _____ i _____ am pm

Podpis tłumacza (Signature of Interpreter/Translator) | Data (Date) | (and) | Godzina (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.

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Chart No.

Name

Unit

(Patient Imprint Card)

ŚWIADOMA ZGODA NA ZNIECZULENIE I/LUB ANALGOSEDACJĘ
(INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA)

FORM B-2

Niniejszym upoważniam _____ (imię i nazwisko lekarza prowadzącego lub upoważnionego świadczeniodawcy opieki zdrowotnej/ **Name of Attending Physician or Authorized Health Care Provider**) lub jego/jej lekarza asystującego i asystentów wybranych i nadzorowanych przez niego/nią do podania mi:

☐ Znieczulenia/**Anesthesia** ☑ Anglosedacji/**Sedation Analgesia**

Wyjaśniono mi zagrożenia, korzyści i alternatywy dotyczące podania takiego znieczulenia i/lub anglosedacji, i uzyskałem zadowalające odpowiedzi na wszystkie moje pytania.

_____ _____ i _____ am

Podpis pacjenta lub rodzica/opiekuna prawnego w przypadku pacjenta nieletniego (Signature of Patient or Parent/Legal Guardian of Minor Patient) | **Data (Date)** | **(and)** | **Godzina (Time)** | **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.

_____ _____ i _____ am

Podpis przedstawiciela służby zdrowia lub opiekuna prawnego (Signature of Health Care Agent/Legal Guardian) | **Data (Date)** | **(and)** | **Godzina (Time)** | **pm**
(Place a copy of the authorizing document in the medical record)

_____ _____ i _____ am

Podpis i określenie charakteru związku zastępcy (Signature and Relation of Surrogate) | **Data (Date)** | **(and)** | **Godzina (Time)** | **pm**

ŚWIADEK (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.

_____ _____ i _____ am

Podpis i tytuł świadka (Signature and Title of Witness) | **Data (Date)** | **(and)** | **Godzina (Time)** | **pm**

TŁUMACZ (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.

_____ _____ i _____ am

Podpis tłumacza (Signature of Interpreter/Translator) | Data (Date) | (and) | Godzina (Time) | pm

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-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