Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(Patient Imprint Card)

CONSENTIMIENTO INFORMADO PARA PROCEDIMIENTOS DIAGNÓSTICOS, MÉDICOS Y QUIRÚRGICOS INVASIVOS (INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES)

FORM B-1

Por la presente autorizo a ______________________________ (Nombre del médico tratante o proveedor de atención médica autorizado / **Name of Attending Physician or Authorized Health Care Provider**) o a su médico tratante asociado perteneciente al mismo servicio y a los asistentes seleccionados y supervisados por él o ella para realizar el siguiente tratamiento médico, operación o procedimiento (en adelante denominado "procedimiento" / **hereafter called the "Procedure"**): **Cardiac Catheterization/Percutaneous Coronary Intervention, Possible Intra-Aortic balloon pump, possible pacemaker. Possible Coronary Artery Bypass Surgery.**

Me han explicado el procedimiento y se me han comunicado las razones por las que necesito el procedimiento. También me han explicado los riesgos del procedimiento. Además, me han comunicado que el procedimiento puede no tener los resultados que espero. También me han informado sobre otros posibles tratamientos para mi problema y lo que podría ocurrir en caso de no recibir tratamiento.

Entiendo que además de los riesgos que me han informado sobre este procedimiento, existen los riesgos inherentes a cualquier procedimiento quirúrgico o médico. Sé que la medicina y la cirugía no son ciencias exactas y que no me han dado garantías de los resultados de este procedimiento.

He tenido suficiente tiempo para conversar sobre mi afección y mi tratamiento con los profesionales que me atienden y me han respondido todas las preguntas a mi entera satisfacción. Creo contar con suficiente información para tomar una decisión informada y acepto que me hagan el procedimiento. Si ocurre algo inesperado y necesito un tratamiento adicional o diferente del que espero, acuerdo aceptar cualquier tratamiento que resulte necesario.

Acepto recibir transfusiones de sangre y otros hemoderivados que puedan ser necesarios junto con el procedimiento que me están realizando. Me han explicado los riesgos, beneficios y alternativas y me han respondido todas las preguntas a mi entera satisfacción.

Si me niego a recibir transfusiones voy a tachar y colocar mis iniciales en esta sección y firmar un formulario de RECHAZO DE TRATAMIENTO.

Acuerdo permitir a este centro conservar, usar o desechar adecuadamente tejidos y partes de órganos que me extirpen durante este procedimiento.

______________________________ ______________ y ______________ am/pm
Firma del paciente o del padre, madre o tutor legal del paciente menor de edad (Signature of Patient or Parent/Legal Guardian of Minor Patient) **Fecha (Date)** **(and)** **Hora (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.

______________________________ ______________ y ______________ am/pm
Firma del agente de salud o tutor legal (Signature of Health Care Agent/Legal Guardian) **Fecha (Date)** **(and)** **Hora (Time)**
(Place a copy of the authorizing document in the medical record)

______________________________ ______________ y ______________ am/pm
Firma y vínculo con el representante (Signature and Relation of Surrogate) **Fecha (Date)** **(and)** **Hora (Time)**

TESTIGO (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.

______________________________ ______________ y ______________ am/pm
Firma y cargo del testigo (Signature and Title of Witness) **Fecha (Date)** **(and)** **Hora (Time)**

INTÉRPRETE/TRADUCTOR (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.

______________________________ ______________ y ______________ am/pm
Firma del intérprete/traductor (Signature of Interpreter/Translator) **Fecha (Date)** **(and)** **Hora (Time)**

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 cordnary 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)

CONSENTIMIENTO INFORMADO PARA ANESTESIA O SEDACIÓN Y ANALGESIA (INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA)

FORM B-2

Por la presente autorizo a ______________________________ (Nombre del médico tratante o proveedor de atención médica autorizado / **Name of Attending Physician or Authorized Health Care Provider**) o a su médico tratante asociado y a los asistentes seleccionados y supervisados por él para administrar:

☐ Anestesia / **Anesthesia** ☑ Sedación y analgesia / **Sedation Analgesia**

Se me han informado los riesgos, beneficios y alternativas a la administración de la anestesia y/o sedación y analgesia y me han respondido mis preguntas a mi entera satisfacción.

______________________________ ____________ y ____________ am/pm
Firma del paciente o del padre, madre o tutor legal del paciente menor de edad (Signature of Patient or Parent/Legal Guardian of Minor Patient) **Fecha (Date)** **(and)** **Hora (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.

______________________________ ____________ y ____________ am/pm
Firma del agente de salud o tutor legal (Signature of Health Care Agent/Legal Guardian) (Place a copy of the authorizing document in the medical record) **Fecha (Date)** **(and)** **Hora (Time)**

______________________________ ____________ y ____________ am/pm
Firma y vínculo con el representante (Signature and Relation of Surrogate) **Fecha (Date)** **(and)** **Hora (Time)**

TESTIGO (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.

______________________________ ____________ y ____________ am/pm
Firma y cargo del testigo (Signature and Title of Witness) **Fecha (Date)** **(and)** **Hora (Time)**

INTÉRPRETE/TRADUCTOR (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.

______________________________ ____________ y ____________ am/pm
Firma del intérprete/traductor (Signature of Interpreter/Translator) **Fecha (Date)** **(and)** **Hora (Time)**

Facility: **Elmhurst Hospital Center**

INFORMED CONSENT PROGRESS NOTE

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

Chart No.*

Name

Unit

(Patient Imprint Card)

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/pm
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 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/pm
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.

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 ________