Facility: **Elmhurst Hospital Center**

INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES

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

Chart No.

Name

Unit

(Patient Imprint Card)

FORM B-1

I hereby permit _____ (Name of Attending Physician or Authorized Health Care Provider) or his/her Associate Attending Physician of the same service, and assistants as may be selected and supervised by him/her to perform the following medical treatment, operation, or procedure (hereafter called the "procedure"):

Paracentesis

The procedure has been explained to me and I have been told the reasons why I need the procedure. The risks of the procedure have also been explained to me. In addition, I have been told that the procedure may not have the result that I expect. I have also been told about other possible treatments for my condition and what might happen if no treatment is received.

I understand that in addition to the risks described to me about this procedure there are risks that may occur with any surgical or medical procedure. I am aware that the practice of medicine and surgery is not an exact science, and that I have not been given any guarantees about the results of this procedure.

I have had enough time to discuss my condition and treatment with my health care providers and all of my questions have been answered to my satisfaction. I believe I have enough information to make an informed decision and I agree to have the procedure. If something unexpected happens and I need additional or different treatment(s) from the treatment I expect, I agree to accept any treatment which is necessary.

I agree to have transfusions of blood and other blood products that may be necessary along with the procedure I am having. The risks, benefits and alternatives have been explained to me and all of my questions have been answered to my satisfaction.

If I refuse to have transfusions I will cross out and initial this section and sign a REFUSAL OF TREATMENT form.

I agree to allow this facility to keep, use or properly dispose of, tissue and parts of organs that are removed during this procedure.

_____ _____ **and** _____ **am**

Signature of Patient or Parent/Legal Guardian of Minor Patient **Date** **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.

_____ _____ **and** _____ **am**

Signature of Health Care Agent/Legal Guardian **Date** **Time** **pm**

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

_____ _____ **and** _____ **am**

Signature and Relation of Surrogate **Date** **Time** **pm**

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.

_____ _____ **and** _____ **am**

Signature and Title of Witness **Date** **Time** **pm**

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.

_____ _____ **and** _____ **am**

Signature of Interpreter/Translator **Date** **Time** **pm**

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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 paracentesis (Identify Procedure) to the above-named patient for treatment of ascites (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: pain, bleeding, infection, hypotension, death damage to the surrounding structures including bowel, blood vessels, nerves, fascia, liver, spleen, bladder, stomach

Benefits: ability to test abdominal fluid for infection and/or alleviate symptoms of increased abdominal fluid

Alternatives (including risks, side effects and benefits): no procedure

Risks related to not receiving the procedure: inability to have an accurate diagnosis, worsening infection, hypotension, respiratory distress, death

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.