Facility: **Elmhurst Hospital Center**

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

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**"):

Lumbar Puncture

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
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)**		**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.

_____	_____	y	_____		am
Firma del agente de salud o tutor legal (Signature of Health Care Agent/Legal Guardian)	**Fecha (Date)**	**(and)**	**Hora (Time)**		**pm**

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

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

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

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
Firma del intérprete/traductor (Signature of Interpreter/Translator)	**Fecha (Date)**	**(and)**	**Hora (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 Lumbar Puncture (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: -Immediate or Delayed Bleeding at site of insertion -Hematoma Formation -Headache - Back Pain -Infection -Lower limb weakness/numbness/pralysis (rare)

Benefits: -Ability to analyze spinal fluid for presence of subarachnoid hemorrhage, infection or autoimmune pathology -In select cases, ability to remove spinal fluid to improve headache

Alternatives (including their risks, side effects and benefits): -No lumbar puncture - this may limit the accuracy of the diagnosis and resulting treatment plan

Risks related to not receiving the procedure: -Inability to most accurately diagnose and treat presenting condition (hemorrhage, infection) which may lead to worsening symptoms

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**

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

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

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