BronxCare
HEALTH SYSTEM

MR# [redacted] CCU-CCUR-05
MD: 8748 FARKAS, DANIEL
[redacted]

CONSENT FOR OPERATION
CONSENT FOR ANESTHESIA
DIAGNOSTIC / THERAPEUTIC PROCEDURE
AND BLOOD TRANSFUSION

INFORMED CONSENT

PART A: Invasive & Operative Procedure

I hereby give authorization and consent to Dr. Farkas and the BronxCare Health System staff to perform an operation and/or diagnostic/therapeutic procedure and/or anesthesia described as a:

RIGHT ☐ LEFT ☐ N/A ☐

Exploratory laparotomy, possible bowel resection, possible primary anastomosis or ostomy creation, possible temporary abdominal closure and all related procedures

(Describe Operation/Diagnostic/Therapeutic Procedure and/or anesthesia)

upon [redacted]

(Name of Patient)

[redacted], has explained the operation and/or diagnostic/therapeutic

(Name of Physician or Practitioner)

procedure(s) and/or anesthesia described, including the significant risks and intended benefits of the operation and/or diagnostic/therapeutic procedure(s) to be performed, the alternative(s) to this procedure, the risks and benefits of the alternative(s) to the operation, and possible consequences if the operation and/or diagnostic/therapeutic procedure and/or anesthesia is not performed. I recognize I have the right to refuse the procedure being offered. I understand that medicine is not an exact science and that the operation and/or diagnostic/therapeutic procedure(s) may not have the benefits, goals or recuperative results intended. I am aware that there are always risks and dangers to life and health associated generally with anesthesia, surgery, use of medication, medical procedures and treatments, which can cause adverse consequences not ordinarily anticipated in advance, and I give this permission with full consent. I acknowledge that no guarantees or assurances have been made to me concerning the results of this operation and/or diagnostic/therapeutic procedure and/or anesthesia. All of my questions have been answered.

Tissues and/or organs removed during the operation and/or diagnostic/therapeutic procedure(s) may be examined, retained or discarded in accordance with Hospital practice.

For surgeries in which residents may perform important parts of the surgery:

- It is anticipated that at the time of surgery, physicians who are in an approved postgraduate residency training program, may perform portions of the surgery, based on their skill, level of competency and availability.
- Residents performing surgical tasks will be under the supervision of the operating practitioner/teaching surgeon, who has knowledge of the resident's skills, and the patient's condition.
- Based on the resident's level of competence, the operating practitioner/teaching surgeon may not be physically present in the same operating room for some or all of the surgical tasks performed by residents.
- As permitted by State law, qualified practitioners such as Physicians Assistants, Nurse Anesthetists or Surgical Assistants may perform important parts in surgery or administer the anesthesia. Such practitioners will be performing only tasks within their scope of practice for which they have been granted privileges by the hospital.
- I acknowledge I have been advised of attending surgeons who may be present during my case.

PART B: Safe Medical Device Tracking

In accordance with federal law and regulations I hereby authorize BronxCare Health System to release my social security number to the manufacturer of any medical device(s) that may be implanted. The manufacturer may use this information to locate me if there is a need to contact me with respect to the medical device.

PART C: Anesthesia

I hereby give authorization and consent to _____ to administer the anesthesia. The anticipated type of anesthesia _____,may change depending on the needs during surgery. The risks, benefits and alternatives to the administration of anesthesia or sedation/analgesia have been explained to me. All my questions have been answered to my satisfaction, and I understand the information.

☐ I consent to the administration of **anesthesia or sedation/analgesia** under the direction of the Department of Anesthesiology.

☐ I consent to the administration of **sedation/analgesia** under the direction of the Attending Physician/Surgeon.

PART D: Blood Transfusion

This consent applies to all transfusions I may receive during my course of treatment at BCHS. I have been informed of the risks, benefits and alternatives of receiving transfusions, and I understand that these risks exist, despite the fact the blood has been carefully tested. The alternatives and the risk and consequences of not receiving this therapy have been explained to me, and all of my questions have been answered to my satisfaction and I understand.

I confirm that I understand the information provided as it affects my decision whether or not to authorize the transfusion of blood or blood products.

I consent to blood transfusion(s), as my physician may deem advisable during the course of my treatment.

☑ I consent to blood transfusion(s).

☐ I refuse blood transfusion(s).

PART E: Authorization and Signatures

I certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the operation, diagnostic/therapeutic procedure and/or anesthesia and offered to answer any questions. The patient or authorized representative states that he/she has understood the information.

Authorized Person Obtaining Consent

[redacted] Signature

[redacted] Date 7:39pm Time

[redacted] Print Name

Attending Surgeon, Anesthetist or Physician

[redacted] Signature

[redacted] Date 9:30 Time

Print Name

Interpreter (if required)

Translation obtained from

Date Time

Operator # / Job Title

Language

Patient or Authorized Representative

[redacted] Signature

Date 7:39 Time

[redacted] Print Name

Relationship to Patient

Witness to Patient/Authorized Representative Signature

[redacted] Signature

Date 7:39 Time

[redacted] Print Name

Relationship to Patient