Jersey City Medical Center | RWJBarnabas HEALTH

CONSENT FOR SURGERY / PROCEDURE

DO NOT WRITE IN THIS AREA

PATIENT LABEL

1 I [redacted]
(PRINT PATIENT'S FULL NAME)
hereby request and [redacted] Medical Center
Dr(s) _____
(my physician(s) or his/her/their designees and or any assistants that may be selected and supervised by him/her/them (collectively the "Medical Center") to perform upon me the above named patient
the following procedure(s): [redacted]
_____ (the "Procedure")

2 The procedure has been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the Procedure. I have also received information regarding: (a) the nature and purpose of the Procedure and related care, treatment, services, medications and interventions; (b) alternatives to the Procedure as well as the relevant risks and benefits of such alternative procedure(s); (c) clinical outcome if I do not elect to have the Procedure; (d) the potential benefits and possible risks, side effects and complications associated with the Procedure including potential problems that might occur during recuperation, and the likelihood of achieving care, treatment and service goals. I understand that the Medical Center's Privacy Notice describes any limitations on the confidentiality of my information, and my Physician has informed me of any special reporting obligations of which he or she is aware.
Among the risks, complications, [redacted] problems explained were: _____

3 I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of the proposed Procedure(s).

4 I consent to the performance of additional operations and procedures different from those now contemplated and deemed necessary or advisable during the course of the authorized Procedure(s) because of unforeseen conditions. The authority under this paragraph shall extend to treating all conditions that require treatment but were not known to the Physician(s) or his/her/their designees and/or associates at the time the Procedure commenced.

5 I consent to the retention or disposal of any tissues or parts which may be removed during the procedure(s).

6 I consent to the photographing, videotaping, or televising of the Procedure for the advancement of medical knowledge and/or education, with the understanding that my/his patient's identity will not be disclosed outside of the Medical Center.

7 I am aware that medical students, manufacturers' representatives and other observers may be permitted in the Operating or Treatment room if approved by the physician(s).

8 I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I agree that all of my questions have been fully answered and satisfactorily. I believe I have adequate knowledge and understanding upon which to base this informed consent.

9 I have been informed and I understand that this consent may be withdrawn at any time prior to the procedure.

[redacted]

Witness
[redacted]
Signature [redacted] Date [redacted]

Relationship if signed other than patient: _____

Signature of Interpreter (if used): _____
Print Name of Interpreter: _____
I.D. Number (if used): _____

Physician's Certification:
I hereby certify that I have explained the nature, purpose, benefits, risks, and/or alternatives to the procedure.
I believe that the patient or his/her representative understands what I have explained and answered. I have reviewed this alternatives prior to the [redacted] and hereby confirm that the Procedure, as specifically described above

[redacted] DATE [redacted]

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