Facility: **Kings County Hospital Center**

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

INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES

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"):

Arterial Catheter

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 (Place a copy of the authorizing document in the medical record)	**Date** **Time** **pm**
_____	_____ 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 Arterial Catheter (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, fever, infection, formation of clots in blood vessels with the rare result of tissue and limb loss, and rarely death. Other:

Benefits: Monitor blood pressure and obtain blood samples for testing. Keep close watch on your blood pressure which could be life saving in a crisis. Other:

Alternatives (including risks, side effects and benefits): Blood pressure monitoring by cuff monitoring which needs to inflate every few minutes. Needle stick each time you need a blood test. Other:

Risks related to not receiving the procedure: Without an arterial catheter the blood pressure cannot be measured closely second by second, which is needed sometimes in crisis situations. Needle-sticks can result in bruising, bleeding and pain.

Other:

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.