Facility: **Kings County Hospital Center**

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

Chart No.

Name

Unit

(Patient Imprint Card)

KONSANTMAN ENFÒME POU PWOSEDI ANVAYISAN, DYAGNOTISK, MEDIKAL & CHIRIJIKAL
(INFORMED CONSENT FOR INVASIVE, DIAGNOSTIC, MEDICAL & SURGICAL PROCEDURES)

FORM B-1

Atravè dokiman sila a mwen bay_____ (Non Medsen Tretan an oswa Pwofesyonèl ki Otorize Bay Swen Sante a/ **Name of Attending Physician or Authorized Health Care Provider**) oswa Medsen Asosye Tretan an ki bay menm sèvis la, ak asistan ke limenm li ka chwazi ak sipèvize, pèmisyon pou fè tretman medikal, operasyon, oswa pwosedi suivan an (ke n ap rele annapre "pwosedi"/**hereafter called the "procedure")**

Yo te esplike m pwosedi a e yo te fè m konnen rezon ki fè mwen bezwen l. Yo te esplike m risk ki genyen nan pwosedi a tou. Anplisdesa, yo fè m konnen pwosedi a ka pa bay rezilta m ap atann nan. Epitou, yo fè m konnen sou lòt tretman posib ki genyen pou kondisyon m nan epi yo di m ki sa ki ka rive si mwen pa resevwa okenn tretman.

Mwen konprann ke anplisde risk ke yo dekri banmwen yo sou pwosedi sa a, gen risk ki ka rive avèk nenpòt pwosedi chirijikal oswa medikal. Mwen konnen ke lamedsin ak operasyon se pa yon syans egzak yo ye, e ke yo pa banmwen okenn garanti sou rezilta pwosedi sa a.

Mwen te gen ase tan pou mwen diskite sou kondisyon ak tretman m nan avèk pwofesyonèl k ap bay swen sante m yo e yo te reponn tout kesyon m te poze yo, e mwen te satisfè ak repons yo. Mwen kwè mwen gen ase enfòmasyon pou m pran yon desizyon enfòme e mwen dakò pou yo fè pwosedi a pou mwen. Si gen yon bagay sanzatann ki rive e ke mwen ta vin bezwen tretman anplis oswa lòt jande tretman apade tretman m ap atann yo banmwen an, mwen dakò pou m aksepte nenpòt tretman ki nesesè.

Mwen dakò pou yo fè transfizyon san ak lòt pwodui sangen pou mwen ki ta ka nesesè ansanm avèk pwosedi m ap resevwa a. Yo te esplike mwen risk, avantaj, ak lòt opsyon ki genyen yo epi yo te reponn tout kesyon m te poze yo,e mwen te satisfè ak repons yo.

Si mwen refize pou yo fè transfizyon pou mwen, mwen pral bare epi mete inisyal mwen nan seksyon sa a epi mwen pral siyen yon fòm REFI POU TRETMAN.

Mwen dakò pou m kite etablisman sa a kenbe, itilize oswa jete konvenableman, tisi ak pati ògàn yo retire yo pandan pwosedi sa a.

_____	_____	ak	_____	am
Siyati pasyan an oswa paran/responsab legal pasyan ki se minè a **(Signature of Patient or Parent/Legal Guardian of Minor Patient)**	**Dat (Date)**	**(and)**	**Lè (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.

_____	_____	ak	_____	am
Siyati reprezantan k ap pran desizyon sou swen sante a/responsab legal la. (Signature of Health Care Agent/Legal Guardian) (Place a copy of the authorizing document in the medical record)	**Dat (Date)**	**(and)**	**Lè (Time)**	**pm**

_____	_____	ak	_____	am
Siyati ak relasyon de ranplasman **(Signature and Relation of Surrogate)**	**Dat (Date)**	**(and)**	**Lè (Time)**	**pm**

TEMWEN (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.

_____	_____	ak	_____	am
Siyati ak tit temwen an (Signature and Title of Witness)	**Dat (Date)**	**(and)**	**Lè (Time)**	**pm**

ENTÈPRÈT/TRADIKTÈ (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.

_____	_____	ak	_____	am
Siyati entèprèt la/tradiktè a (Signature of Interpreter/Translator)	**Dat (Date)**	**(and)**	**Lè (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 _____(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:_____

_____

_____

Benefits:_____

_____

Alternatives (including their risks, side effects and benefits): _____

_____

Risks related to not receiving the procedure: _____

_____

_____

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.