Facility: **Kings County Hospital Center**

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

Chart No.

Name

Unit

(Patient Imprint Card)

CONSENTIMIENTO INFORMADO PARA ANESTESIA O SEDACIÓN Y ANALGESIA (INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA)

FORM B-2

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 y a los asistentes seleccionados y supervisados por él para administrar:

❑ Anestesia / **Anesthesia** ❑ Sedación y analgesia / **Sedation Analgesia**

Se me han informado los riesgos, beneficios y alternativas a la administración de la anestesia y/o sedación y analgesia y me han respondido mis preguntas a mi entera satisfacción.

_____ _____ **y** _____ **am**
Firma del paciente o del padre, madre o tutor legal del paciente menor de edad **Fecha (and) Hora pm**
(Signature of Patient or Parent/Legal Guardian of Minor Patient) **(Date) (Time)**

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 **Fecha (and) Hora pm**
(Signature of Health Care Agent/Legal Guardian) **(Date) (Time)**
(Place a copy of the authorizing document in the medical record)

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

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 (and) Hora pm**
(Date) (Time)

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 (and) Hora pm**
(Date) (Time)

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INFORMED CONSENT PROGRESS NOTE

(The Informed Consent Form HHC 100 B-2 on the reverse side must also be completed)

I explained the risks, benefits, side effects and options of the proposed anesthesia and/or sedation analgesia to the above-named patient.

As I explained to the patient, the risks, benefits, side effects, alternatives and intended goals of the anesthesia and/or sedation analgesia (including potential problems with recuperation) include but are not limited to:

Risks and Side Effects: _____

_____

_____

Benefits: _____

_____

_____

Alternatives to Anesthesia and/or sedation analgesia (including the risks, side effects and benefits thereof):

_____

_____

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 ANESTHESIOLOGIST'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 Anesthesiologist **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.