NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

INFORMED CONSENT FOR ANESTHESIA AND/OR SEDATION ANALGESIA

Chart No.

Name

Ward No.

(Patient Imprint Card)

FORM B-2

I hereby authorize _____ (Name of Attending Physician or Authorized Health Care Provider) or his/her Associate Attending Physician and assistants as may be selected and supervised by him/her to administer:

❑ Anesthesia ❑ Sedation Analgesia

I have been informed of the risks, benefits and alternatives of the administration of such anesthesia and/or sedation analgesia and my questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Parent/Legal Guardian of Minor Patient **Date**

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 next of kin who is assenting to the treatment for the patient, must be obtained.

_____ _____

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

_____ _____

Signature and Relation of Next of Kin **Date**

WITNESS:

I, _____ am a facility employee who is not the patient's physician or authorized health care provider named above and I have witnessed the patient or other appropriate person voluntarily sign this form.

_____

Signature and Title of Witness

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.

_____

Signature of Interpreter/Translator

FOR FACILITY USE ONLY

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INFORMED CONSENT PROGRESS NOTE

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

Chart No.

Name

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I explained the risks, benefits 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.

Signature of Attending Anesthesiologist or Authorized Health Care Provider* **Date**

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 next of kin has assented to the proposed treatment for the patient, the next of kin's relationship is indicated on the consent form.

Signature of the Attending Anesthesiologist **Date**

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.