Facility:

NYC HEALTH+ HOSPITALS

FÒM POU BAY ENFÒMASYON POU PASYAN EPI POU PRAN KONSANTMAN ENFÒME POU SEDASYON LEJÈ/INFORMED CONSENT FOR MODERATE SEDATION

Chart No.

Name

Unit

(Patient Imprint Card)

FORM B-2(b)

Nan fòm sa a mwen, bay otorizasyon pou _____ (Non Doktè [yo] k ap Bay Tretman an oswa Pwofesyonèl Swen Sante Otorize [yo]) oswa Doktè Asosye [yo] k ap Bay Tretman an ak lòt asistan otorize yo, pèsonèl entèn oswa lòt pwofesyonèl swen, kèk nan yo ka an fòmasyon, e ke yo ka chwazi ak sipèvize pou administre sedasyon lejè a.

Yo te ban mwen enfòmasyon sou risk, avantaj ak lòt chwa administrasyon sedasyon lejè a epi mwen te satisfè avèk repons yo te bay pou tout kesyon mwen yo.

		epi / and		**am/am**
Siyati Pasyan an oswa Paran/ Responsab Legal li/Signature of Patient or Parent/Legal Guardian of Minor Patient	**Dat / Date**		**Lè /Time**	**pm/pm**

If the patient cannot consent for themself, 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.

		epi / and		**am/am**
Siyati Ajan Swen Sante/Responsab Legal/Signature of Health Care Agent/Legal Guardian (Place a copy of the authorizing document in the medical record)	**Dat / Date**		**Lè /Time**	**pm/pm**
		epi / and		**am/am**
Siyati ak Relasyon Reprezantan an/Signature and Relation of Surrogate	**Dat / Date**		**Lè /Time**	**pm/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 an authorized representative, voluntarily sign this form ☐ ; **OR** consent to treatment telephonically ☐ . **(Check one box.)**

I, _____, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed that the patient is **unable** to sign this form ☐; **OR** that the patient or an authorized representative, **refused** to sign this form ☐ **.(Check one box.)**

		and		**am**
Signature and Title of Witness	**Date**		**Time**	**pm**

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)

I have provided an accurate and complete interpretation of an explanation/discussion of this form between the health care provider(s) and the patient or the patient's authorized representative.

		and		**am**
Signature of Interpreter (if present), ID# and Agency Name	**Date**		**Time**	**pm**

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INFORMED CONSENT PROGRESS NOTE

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

I explained the risks, benefits, side effects and options of the proposed **moderate sedation** to the above-named patient. As I explained to the patient, the risks, benefits, side effects, alternatives and intended goals of the anesthesia (including potential problems with recuperation) include but are not limited to:

Risks and side effects of moderate sedation: Nausea, vomiting, aspiration, itching, allergic reaction to medication, drowsiness, headache, pain at surgical site, decreased breathing, decreased or increased blood pressure or heart rate, irregular heartbeat, and/or local irritation at IV site, cardiac arrest, death

Benefits: Improved comfort during the procedure, decrease or prevent pain and reduce memory of the procedure

Alternatives to Moderate Sedation (including the risk, side effects and benefits thereof):

General Anesthesia (GA)	*Monitored Anesthesia Care (MAC)*	*Straight Local*
Risks and Side Effects: Swelling, irritation, injury to teeth/lip/gum/tongue/throat or voice box, allergic reaction, nausea, vomiting, dry mouth, sore throat, hoarseness, headache, dizziness, drowsiness, irregular heartbeat, low/high blood pressure, fast/slow heartbeat, heart	**Risks and Side Effects: Nausea, vomiting, allergic reaction, headache, discomfort at surgical site, possible awareness of procedure, slow/fast heartbeat, low/high blood pressure, irregular heartbeat, cardiac arrest, death**	**Risks and Side Effects: Discomfort at surgical site, aware of procedure, increased anxiety**
Benefits: No anxiety, no awareness, able totolerate procedure better	**Benefits: Faster recovery, less anxiety**	**Benefits: Awake, breathing on your own, faster return to normal activities**

Patient specific risks/benefits/alternatives (if any): _____

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 License 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 License 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.