CONSENT TO OPERATION OR PROCEDURE AND ANESTHESIA

I request and consent to a surgical procedure called ______________________________

____

and I understand that the purpose of this procedure is ______________________________

____

This procedure will be performed by ______________________________

I have been advised that this procedure may have potential benefits, risks, or side effects associated with it, including but not limited to ______________________________

____

including potential problems that might occur during recuperation. I have been advised of the alternatives, risks, benefits and side effects related to the alternatives.

- **I consent** to the administration of anesthesia and related drugs, as deemed necessary by the staff members from **Stony Brook Anesthesiology, UFPC.**
- **I understand** that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment.
- **I understand** that portions of the operation may be photographed or videotaped. I consent to this as long as my identity is not revealed. I understand that these photographs may be used for teaching and may not be a part of the permanent record. I also understand that residents, medical, nursing and allied health students/trainees may be present during the procedure and they may observe or assist in my care, under the direction of my surgeon and other hospital staff members.
- **I understand** that in the event one or more of my health care providers sustains a needle stick/sharp injury or exposure to my blood/bodily fluids that blood may be drawn and may be tested for hepatitis and the results of that hepatitis testing disclosed to the health care providers who sustained the exposure.
- **I also understand** that a sales/clinical representative may be present during the procedure, but may not participate in the procedure.
- **I impose** no specific limitations or restrictions on my treatment other than: ______________________________

____

(Patient must specify restriction or write "None")

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of this treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

Signature of Patient, Parent, Guardian, Health Care Agent or other representative of patient*	Relationship (if other than Patient)	Date	Time

*If other than patient, provide a reason ______________________________

Signature of Witness (Age 18 or older, other than Practitioner performing procedure)	Title or Relationship to Patient	Date	Time

___ An interpreter or special assistance was used to obtain consent from this patient. ______________________________ **(Name of Interpreter)**

___ **I verify that I have explained the procedure, relevant risks, benefits and alternatives, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services.**

___ **I verify that patient has an active Do Not Resuscitate order; DNR Status Form # RM2C445 completion required, OR**

___ **I verify that patient does not have an active Do Not Resuscitate order at this time.**

Signature of Practitioner	ID #	Date	Time

OR2C261 (4/12)

O R 2 C 2 6 1

Stony Brook Medicine

CONSENT TO OPERATION OR PROCEDURE AND ANESTHESIA

PHYSICIAN VERIFICATION

(Check all that apply)

PART A. ASSESSMENT AND REASSESSMENT OF PATIENT:

(**ONLY** Outpatient / Same Day Surgical and Invasive Procedures **MUST** have the History and Physical examination completed within 30 days, updated within 24 hours of surgical/invasive procedure.)

I verify that I have reviewed this consent and confirm the accuracy of the document including the description of the procedure. I have reviewed the operative/procedural plan with the Anesthesiologist and the Nursing staff. I have examined the patient and updated the patient's current condition, and/or completed a new History and Physical, and determined this specific operation/procedure is indicated at this time.

PART B. SURGERY/PROCEDURE SIDE/SITE VERIFICATION

ATTENDING SITE/SIDE VERIFICATION

☐ I have marked the site(s) and side(s) of surgery as required by Stony Brook University Medical Center policy.

OR

☐ The site/side marking(s) of the ______________________ as required by Stony Brook University Medical Center policy could not be done for the following reason(s): ____

____

______________________	______________	__________	________
Attending Performing Surgery/Procedure Signature	**ID #**	**Date**	**Time**

ANESTHESIOLOGY SITE/SIDE VERIFICATION (When present)

I confirm that I have verbally verified the correct operative/procedural site/side with the patient. If the **patient's** status prohibits verbal verification of correct site/side, **verification** obtained utilizing the medical record.

______________________	______________	__________	________
Attending Anesthesiologist Signature	**ID #**	**Date**	**Time**

NURSE SITE/SIDE VERIFICATION

I confirm that I have identified the operative site/side and that the patient is marked or an exception was documented as above. There is oral agreement among the attending performing the operation/ procedure, the Anesthesiologist and myself.

______________________	______________	__________	________
Nurse Signature	**ID #**	**Date**	**Time**

****Documentation of the Time Out Process is noted in the Intra-Operative Nurses Record or Procedure Note.***

☐ An interpreter or special assistance was used to verify site/side verification from this patient.

____

(Name of Interpreter)