NewYork-Presbyterian

45350

THORACENTESIS

CONSENT FOR SURGICAL OR OTHER INVASIVE PROCEDURES

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

I authorize _____ **MD/NP/PA** PA **er)** and NewYork-Presbyterian Hospital (NYP) and its staff to perform the following surgical/invasive procedure.

Procedure Side, Site and Level – Check applicable box(es): (No acronyms or abbreviations except for spinal levels)

LEFT Side: ☐ **RIGHT** Side: ☐

Procedure: **Thoracentesis**

My signature below means that:

1. I understand the following information which has been explained to me:
   - The nature and purpose of the surgery or procedure and the medical risks and benefits of the surgery or procedure.
   - The likelihood of achieving the treatment goals.
   - The potential problems that might occur during recuperation.
   - Any other reasonable treatment choices including no treatment and the medical risks and benefits.
   - The practice of medicine is not an exact science and no guarantee has been made to me about the outcome of the surgery or procedure.
   - That tissue, organ or body parts removed during surgery will be used for medical diagnosis and thereafter any remaining tissue, organs or body parts for the advancement of medical science.
   - There are medical risks and benefits of anesthesia that will be explained to me by the person or team providing the anesthetic.
2. I have had the chance to ask questions and my questions have been answered to my satisfaction. I consent to the procedure described above.

   By initialing below, I agree to allow:

   _____ A surgical product representative to be present.

   _____ Approved visitors to be present.

   _____ Photography and/or filming for internal medical study/education or performance improvement purposes.

			11/11/2017	Time: _____ AM/PM
(Patient/Health Care Agent (HCA)/ Guardian/Family Signature/Verbal Consent)	**(Printed Name)**	**(Relationship to Patient)**	**mo./day/year (date)**	
			11/11/2017	Time: _____ AM/PM
(Witness confirming Patient/HCA/ Guardian/Family Signature/Verbal Consent)	**(Printed Name)**	**(Relationship to Patient)**	**mo./day/year (date)**	

☐ Check this box if telephone/verbal consent. Print the name/relationship of the person consenting verbally in the above appropriate spaces.

☐ Check this box if an interpreter was involved; Interpreter Name:_____ Code:_____

If the patient is under 18, obtain permission from parent or legal guardian, unless the patient is married or a parent.

Correct Surgery/Procedure, Site/Side Verification, Attending Physician Attestation of Informed Consent:

(To be completed by Attending MD/appropriately credentialed practitioner performing the surgery/procedure on day of procedure or 24 hours prior to procedure for inpatients.)

Date: 11/11/2017 Time:_____ AM/PM

Thoracentesis

LEFT Side: ☐ **RIGHT** Side: ☐

Patient/HCA/Guardian/Family (Signature)_____

Nurse (Signature)_____ **Nurse** (Print Name)_____

Attending MD/Appropriately Credentialed Practitioner (Signature)_____ MD/NP/PA/ PA

Attending MD/Appropriately Credentialed Practitioner (Print Name)_____ ID Code_____

□ Check this box if interpreter was involved. Interpreter Name_____ Code_____

A DOCUMENTED TIME-OUT MUST BE PERFORMED

45350 Rev. (7/16)