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 and side effects including but not limited to ____________________________

__________________________

I have been advised of the alternatives, benefits and side effects related to the alternatives. I have been advised of the likelihood of achieving my goals and any potential problems that might occur during recuperation.

- I consent to the administration of anesthesia and related drugs, as deemed necessary by the staff members from Stony Brook Anaesthesiology, 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/procedure may be photographed or videotaped. I understand that every attempt will be made to conceal my identity. I understand that some of these photograph/ videotapes may be used for teaching and may not be maintained or be a part of my medical record. I also understand that photographs/videotapes to plan, monitor or document my treatment may be part of my medical record.
- I 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/or other hospital staff members.
- I 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 unless written below:

__________________________

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 or authorized representative ____________________________

Relationship (if other than Patient) ____________________________

Date ____________________________

Time ____________________________

*If other than Patient, provide a reason ____________________________

Signature of Witness ____________________________

Title or Relationship to Patient ____________________________

Date ____________________________

Time ____________________________

(Age 18 or older, other than Practitioner performing procedure)

An interpreter or special assistance was used ____________________________

(Name of Interpreter) ____________________________

ID# as applicable ____________________________

I verify that I have explained the procedure, relevant risks, benefits and alternatives, benefits and side effects related to alternatives, potential problems during recuperative phase, treatment and services, and possible results of not receiving care.

Signature of Practitioner ____________________________

ID# ____________________________

Date ____________________________

Time ____________________________

*COMPLETED CONSENT FORM VALID UP TO FOUR MONTHS*
CONSENT TO OPERATION OR PROCEDURE AND ANESTHESIA

ASSESSMENT AND REASSESSMENT OF PATIENT VERIFICATION

Only Outpatient /Same Day Surgical and Invasive Procedures **MUST** have the History and Physical Examination completed within 30 days and updated within 24 hours of surgical/invasive procedure.

**SURGERY/PROCEDURE SIDE/SITE VERIFICATION** Check one:

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

**OR**

☐ The site/side marking(s) of the ________________________ as required by Stony Brook University Hospital policy could not be done for the following reason(s) ________________________________________________________________

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 reviewed the History and Physical, examined and reassessed the patient and verify that there are no new findings. If new findings have been identified, the History and Physical has been updated accordingly. I verify that I have reviewed this consent and confirm the accuracy of the document including the description of the procedure. I have determined this specific operation/procedure is indicated at this time.

Attending Physician Performing Surgery/Procedure Signature  ID# Date Time

ANESTHESIOLOGY SITE/SIDE VERIFICATION

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 was 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 Physician 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 Report or Universal Protocol/Time Out Note.*

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

(Name of Interpreter)  ID# as applicable Date Time