A S 2 C 0 1 1

Stony Brook Medicine

Stony Brook, NY 11794

CONSENT FOR PAIN PROCEDURE OR REGIONAL ANESTHESIA

I request and consent to a regional anesthesia/pain procedure called _____
(Practitioner must fill in complete name of procedure)

and I understand that the purpose of this procedure is _____

_____
(Practitioner must describe procedure in non-medical terms)

_____

This procedure will be performed by _____
and/or his/her associate(s) and any assistants he/she designates.

I have been advised that this procedure may have potential benefits, risks, or side effects associated with it, including, but not limited to: bleeding, infection, failure to achieve expected result, pain, nerve damage/paralysis, potential injury to a limb while numb, headache, backache, allergic reactions, toxic drug reactions which may cause seizures, and damage to any and all surrounding tissue, including potential problems that might occur during recuperation. I have been advised of the alternatives, the risks, benefits and side effects related to alternatives.

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. 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 needlestick/sharp injury or exposure to my blood/bodily fluids that blood may be drawn and may be tested for hepatitis and the result 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. All blank spaces are completed **or** lined out, prior to my signing this document.

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

Signature of Witness (Age 18 or older, other than Practitioner performing this 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.

Signature AD # of Practitioner	**Date**	**Time**

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CONSENT FOR PAIN PROCEDURE OR REGIONAL 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)