Mount Sinai

The Mount Sinai Hospital
One Gustave L. Levy Place
New York, NY 10029

Date

Name

Unit #

Sex/DOB

Physician Service

PERMISSION SHEET #1

PERMISSION FOR OPERATION AND/OR PROCEDURE AND ANESTHESIA

1. I hereby authorize Doctor_____and/or those associates or assistants he/she may designate to perform upon _____ the following treatment(s), operation(s), and/or procedure(s) to include:
   (NAME OF PATIENT OR MYSELF)

   _____

   _____

2. Dr._____ has fully explained to me the nature and purposes of the treatment(s)/operation(s)/procedure(s) and has also informed me of the benefits, risks and possible complications, as well as the possible alternatives to the proposed treatment(s)/operation(s)/procedure(s). I have been given an opportunity to ask questions, and all my questions have been answered, fully end satisfactorily.

3. I understand that during the course of the operation(s)/procedure(s)/treatment(s) unforeseen conditions may arise which necessitates procedure(s) different from those contemplated. I consent to the performance of additional operation(s)/procedure(s)/treatment(s) which the above-named physician or his/her associates/assistants may consider necessary.

4. I also consent to the administration of anesthesia/sedation/analgesia deemed necessary under the direction of an authorized physician. I have been made aware of the possible risks, consequences, and alternatives associated with the administration of these agents.

5. I further consent to the transfusion of blood or blood components as deemed necessary in the judgement of the physician, or his/her associates/assistants. The benefits and alternate forms of treatment have been explained to me, as well as the possible risk(s) and adverse consequences.

6. I hereby authorize the release of my social security number to the manufacturer of any medical device(s) that may be implanted, in accordance with federal laws and regulations.

7 Any organ (s)/tissue(s)/implant(s) surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or organs may be disposed of in accordance with accustomed practice.

8. For medical, scientific or educational purposes, I consent to the photographing, videotaping and/or closed circuit televising, and publication, thereof, of the operation/procedure/treatment to be performed, provided my identity is not revealed. I also consent to the admission of observers in the Operating or Treatment Room.

9. I understand that during the course of the operation(s)/procedure(s)/treatment(s), a manufacturers representative may provide technical support,

10. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation(s)/procedure(s)/treatment(s). I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs to which I do not consent.

Patient, Relative, or Guardian*	_____ Print Name	_____ Signature	_____ Date / Time	(_____) Relationship
Signature Witness	_____ Print Name	_____ Signature	_____ Date / Time	

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form 1$ only documentation that the informed consent process took place. I remain responsible for having obtained the consent from the patient.

_____ Print Name	_____ Signature	_____ Date / Time	_____ Dict #

** The signature of the patient must be obtained unless the patient is under the age of 19 or incompetent.*

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.