

NEW YORK-PRESBYTERIAN HOSPITAL
Columbia Presbyterian Medical Center

**PERMISSION FOR OPERATION/
DIAGNOSTIC/THERAPEUTIC PROCEDURE**

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

I hereby give authorization and consent to Dr. _____
and New York Presbyterian Hospital and its staff to perform an operation/diagnostic/therapeutic procedure described
as

Right Left NA

(Describe Operation/Diagnostic/Therapeutic Procedure)

upon _____
(Name of Patient)

The nature, intended purpose and significant risks and consequences of such operation/diagnostic/therapeutic
procedure, as well as the alternatives if the operation/diagnostic/therapeutic procedure is not performed, have been
explained to and discussed with me by

(Name of Physician/Appropriately Credentialed Practitioner)

and I give this permission with full knowledge and understanding thereof. I understand that medicine is not an exact
science and the possibility that the operation/diagnostic/therapeutic procedure may not have the benefits or result
intended. I am also aware that there are always risks and dangers to life and health associated generally with
anesthesia, surgery, use of medication, medical procedures and treatments which can cause adverse consequences
not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

I further grant permission for the use of such tissues and/or organs, as it may be necessary to remove during said
operation/diagnostic/therapeutic procedure, for purposes of pathological diagnosis and thereafter for the
advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this
Hospital may designate.

*Signature _____ (Relationship to Patient) _____ Date _____

*NOTE: If the patient is under eighteen (18) years, the permission of the patient's parent or legal guardian must be
obtained, unless the patient is married or the parent of a child.

I have discussed the nature and purpose of the above operation/diagnostic/therapeutic procedure, and the associated
risks, consequences and available alternatives, with the person signing above, and I am satisfied that he/she
understands them

M.D. ID Code: _____

Signature of Physician/Appropriately Credentialed
Practitioner Providing Explanation)

Day of Surgery/Procedure site/side verification: (to be completed on day of surgery)

Date: _____ Right Side Left Side NA

Signatures

Patient/Guardian: _____

RN: _____

Surgeon/Appropriately Credentialed Practitioner: _____

Surgeon (Print Name): _____ ID Code: _____

PERMISSION FOR BLOOD TRANSFUSION

IF NO PLATE, PRINT NAME, SEX, DATE OF BIRTH AND MEDICAL RECORD NO.

I will accept Blood/Blood Products Yes No

Restrictions/Limitations _____

1. I authorize New York Presbyterian Hospital and its staff to administer to me, or the named patient, blood transfusion(s) and/or factor concentrate infusion as indicated.
2. In connection with my consent to this procedure, my physician has provided me with information about, and discussed and explained to me the following:
 - A. The reason(s) for transfusion(s), a description of the procedure, the benefits and risks, all alternatives including autologous and directed donation, as well as the risks and consequences of not receiving a transfusion.
 - B. That a blood transfusion is not always successful and that no guarantee or assurance has been given to me or anyone concerning the results of transfusion, and that I may be subject to ill effects as a result of receiving blood and/or blood products.
 - C. That this consent applies to all transfusions I receive during this hospitalization and if I am an outpatient to all transfusions during the course of this treatment.
3. I confirm that I have read (or have had read to me) the above consent and fully understand all information given to me. All my questions have been answered.

Patient/Health Care Agent/Guardian/Relative: _____ (Signature)

_____ (Print Name)

Relationship if other than patient: _____

Date: _____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to transfusion and have offered to answer any questions. I believe that he/she fully understands what I have explained and answered, and consents to undergo the proposed procedure.

Physician: _____ MD (Signature)

Physician ID Code: _____ Date: _____

Physician: _____ MD (Print Name)

***NOTE: The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of eighteen (18) or is otherwise unable to consent.**

* "Blood Transfusion" means the administration of red cell, white cell, platelet, cryoprecipitate and plasma products.