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MONTEFIORE

MONTEFIORE MEDICAL CENTER
The University Hospital
for the Albert Einstein College of Medicine
Henry & Lucy Moses Division
Jack D. Weiler Division

CONSENT FORM

(to be signed by patient wherever applicable)

ADDRESSOGRAPH

Date _____, 20____ Time _____ A.M./P.M.

I. PERMISSION FOR OPERATIVE AND/OR DIAGNOSTIC PROCEDURE AND/OR TREATMENT

1. I hereby authorize Dr. Kaskel or associates or assistants of his/her choice at Montefiore Medical Center to perform upon me/the patient named above the following operation(s) and/or procedure(s): PLEASE PRINT OR TYPE, USE LAY TERMINOLOGY & INDICATE LEVEL OF SPINAL SURGERY, RIGHT AND LEFT MUST BE WRITTEN IN THEIR ENTIRETY.

   hemodialysis/peritoneal dialysis

2. Dr. (home unit) has fully explained to me the nature and purposes of the operation(s) procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results of the above operation(s), treatment(s) or procedure(s).
3. It has been explained to me that during the course of an operation unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) set forth in paragraph 1. I therefore authorize and request that the above named surgeon, his associates and/or assistants perform such related surgical procedures and administer whatever is necessary and desirable in the exercise of their professional judgment.
4. I further consent to the administration of such anesthesia, sedation and/or blood transfusions as may be considered necessary. I recognize that there are always risks to life and health as well as benefits and alternatives associated with anesthesia, sedation and blood transfusions and these have been explained to me.
5. I further consent to disposal by hospital authorities, or possible use for research purposes, in accordance with its accustomed practice, of any tissues or parts which may be removed.
6. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

Interpreter if required

SIGNATURE

PRINT NAME AND ADDRESS

Witness

SIGNATURE

PRINT NAME

Patient/Relative or Guardian

SIGNATURE

PRINT NAME

RELATIONSHIP IF SIGNED BY PERSON OTHER THAN PATIENT

DATE SIGNED

Physician obtaining consent _____ _____ _____
SIGNATURE PRINT NAME DATE

II. INFORMED CONSENT DISCUSSION: I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed procedure(s)/operation(s), and sedation and/or blood/blood products, when applicable. I have offered to answer any questions and fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Remarks: Dialysis at camp

Home Unit Physician _____ _____ _____
SIGNATURE PRINT NAME DATE

III. ATTENDING PHYSICIAN OPERATIVE SITE/SIDE VERIFICATION: I hereby confirm that the procedure described above, including laterality, where applicable, is correct.

Attending Physician _____
SIGNATURE (To be completed on the day of surgery.) DATE TIME