OR2C261

Stony Brook Medicine
Stony Brook, NY 11794

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.

X _____ _____ _____ _____

Signature of Patient or authorized representative | **Relationship (if other than Patient)** | **Time** | **Date**

***If other than Patient, provide a reason** _____

X _____ _____ _____ _____

Signature of Witness | **Title or Relationship to Patient** | **Time** | **Date**

(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.

X _____ _____ _____ _____

Signature of Practitioner | **ID#** | **Time** | **Date**

COMPLETED CONSENT FORM VALID UP TO FOUR MONTHS