Jacqueline E Jones, M.D.

1175 Park Avenue, Suite 1-A
New York, New York 10128
(212) 996-2559

Day Surgery Instructions for Manhattan Eye, Ear & Throat Hospital

Dear Patient,

You have been scheduled for your procedure at Manhattan Eye, Ear & Throat Hospital, 210 East 64th Street, New York, NY 10021, on ____ .

The following is a pre-operative guide that must be completed prior to your surgery.

1. There are five forms attached (A,B,C, D & your fee agreement). Forms A,B, C and the fee schedule must be completed and returned to our office as soon as possible via fax at 212-981-9832 or by e-mail: MBarrera@ParkAvenueENT.com

2. All patients must have a medical clearance in writing from their primary care physician (Form D). This form must be completed and returned to our office at least one week (5 days) prior to surgery via fax at 212-981-9832 or e-mail: MBarrera@ParkAvenueENT.com

3. Blood work is not required by Manhattan Eye, Ear & Throat Hospital.

4. If you are 50 or over you will need an EKG and delivered to our office at least one week prior to surgery via fax 212-981-9832

5. **Aspirin or aspirin-like products (i.e. Advil, Aleve, Motrin or Nuprin) and Vitamin E should not be taken 2 weeks prior to or 2 weeks after surgery.** If needed, Tylenol may be taken.

6. Solid foods are not allowed after midnight prior to the morning of surgery.

7. PLEASE call the office if you develop a fever within a few days of your surgery.

8. Manhattan Eye, Ear & Throat Hospital will call you the day before surgery and let you know what time to arrive and give you pre-operative instructions.

9. Please be certain to schedule a post-operative appointment at our office.

Sincerely,

Maureen Barrera
Surgical Coordinator
212-996-2559
212-981-9832 - Fax
MBarrera@ParkAvenueENT.com

Instructions Prior to Surgery

Jacqueline Jones, MD

I know that it can be very stressful preparing for surgery. The following instructions may help. After reading them carefully, please let me know if there is anything that you do not understand about the operation.

MEDICATION

Two weeks before the surgery, stop using aspirin, Advil, Motrin, ibuprofen, or any similar drug that can cause bleeding problems. **Do not start using such drugs again until two weeks after the operation**. Use only Tylenol or Tylenol with codeine for pain. If you or your child takes any medicine on a regular basis for health reasons, let me know so we can decide whether or not it should be continued.

PREOPERATIVE TESTS

Before most operations I do require a blood count. Adults need a blood count and blood clotting tests. Certain operations might require a CT scan or other test, but I will discuss this with you if necessary.

MEDICAL CLEARANCE

Your physician or your child's pediatrician must provide a complete written history and physical examination for the anesthesiologist. We have a form for this at the office that you can use, but any written report from your doctor is fine. Ideally, this should be delivered to my office at least 2 days (but not more than one month) before the surgery date. However, it is best to bring a copy with you on the day of surgery to ensure that the operation will not be delayed.

SICKNESS

It is very common for children's surgery to be cancelled due to a cold or other infection, especially in the winter. This is mainly because the risk of anesthesia goes up if a patient has a respiratory infection. The final decision is made by the anesthesiologist on the morning of surgery. While operations are not cancelled for minor symptoms, if your child is clearly sick with fever and/or a cough during the week before surgery, please check with me about rescheduling.

TIME OF SURGERY

The hospital is continually adding and removing cases to a busy schedule, and therefore does not assign starting times until each afternoon for the following day. The correct time will be given to you by the hospital. Pleases call the hospital between 4-7 PM the day before the surgery.

Please realize that the length of an operation can vary due to unforeseen circumstances, and a procedure may take longer than anticipated. You should understand that each patient has to be given our full attention for safety's sake, even if it means delaying the cases that follow. Therefore, the starting time that you are given is an estimate, and the later in the day you are scheduled, the more likely there is to be some degree of delay.

EATING AND DRINKING

Children should be watched carefully before surgery, since they may try to eat or drink, which will delay or cancel their operation. This is because it is dangerous to have anything in the stomach when anesthesia is given. **CLEAR liquids**, such as water, clear jello or apple juice (not cider), are OK up to three hours before the time of surgery. **Everything else (including food and milk) must not be taken for eight hours prior to the operation**.

REGISTRATION

Please arrive at the Hospital admissions desk at least 1 hour prior to your surgery time. The ambulatory surgery center at Manhattan Eye, Ear and Throat Hospital (210 E 64th street, between 2nd and 3rd) is located on the 7th floor. Their phone number is 212-838-9200.

Jacqueline Jones, MD
(212) 996-2559
(212) 996-2703 (fax)
www.ParkAvenueENT.com

Patient Name: ____________________________

Date of Surgery: _________________________

Jacqueline E. Jones, MD

1175 Park Avenue, Suite 1-A
New York, New York, 10128
(212) 996-2559

Estimated Surgical Fee Agreement & Cancellation Policy

Patient Name:______________________________________D.O.B.:______________

Surgical Date:____________________ Surgeon: Jacqueline E. Jones, MD

The following is a pre-operative estimate of surgical charges for Dr. Jacqueline E. Jones, based on the procedure planned and outlined below. Findings during surgery may necessitate different and/or additional procedures by Dr. Jones. Such changes may alter the fees, which you are being quoted. If so, a Final Fee agreement will be prepared for you after the surgery by our billing department.

As with any hospital-based surgery, you can expect a bill and/or statement from the hospital and Anesthesiologist for their services.

______Dr. Jones participates with your insurance: therefore we will pre-certify the procedure(s) below and bill your carrier. As with all insurances, most plans include co-payments, deductibles and other expenses, which must be paid by the patient. The responsible party will be responsible for the balance of these charges once the insurance company has paid their share. However, if your insurance is cancelled or is not in effect on the day of surgery and you neglect to inform us, you will be responsible for the full surgical fee.

______Either you have no insurance coverage for these services or Dr. Jones does not participate with your insurance plan. Therefore payment in full is expected on the day of surgery. You may leave a credit card number or a check with the billing department that will be processed following surgery. Upon processing the payment we will forward a receipt. As a courtesy, we will bill your insurance carrier directly on your behalf. All insurance reimbursements will be sent directly to the subscriber from the insurance company.

Cancellation Policy

We reserve a specific length of time for your procedure and would greatly appreciate that any cancellations or rescheduling be done at least 5 days in advance of your procedure. If we do not receive notice that the procedure needs to be cancelled or rescheduled in advance of 5 days, we will apply a cancellation fee, in the amount of $500, to your account. We understand that unexpected and inevitable events can and will occur and ask you to inform our office as soon as possible in the event of such.

We will waive the fee if your physician or pediatrician requests a cancellation due to medical reasons.

We appreciate your cooperation and understanding regarding our policy. Should you have any questions or concerns, please do not hesitate to contact our office at 212-996-2559 x 5.

Planned Procedures(s):

CPT Code	Procedure	Fee
	Total Estimated Fee	

Acknowledgement of Responsibility

By signing this document I accept the estimated surgical fees and cancellation policy and acknowledge that the total fee may change as a result of the clinical findings during surgery, and I assume full responsibility for final payment of all surgical charges and/or cancellation fee.

______________________________ ______________________________

Patient/Responsible Party Signature Date Responsibility Party Name (Print)

Lenox Hill Hospital

FORM A
REGISTRATION

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to **866-219-5545**

☐ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to **866-231-1027**

Date of Surgery: ______ / ______ / ______

Physician's Name: ______________________

PATIENT INFORMATION Name: Last First

Address: Street City Apt # State Zip

County Of Residence: Phone ( ) S.S. # — —

RACE:
☐ Asian ☐ Black ☐ White
☐ Hispanic ☐ American Indian

SEX: ☐ Male ☐ Female

MARITAL STATUS:
☐ Married ☐ Widowed
☐ Single ☐ Divorced
☐ Separated

DATE OF BIRTH

Month | Day | Year

Mother's Maiden Name

Patient's Maiden Name

Place of Birth

Are you an Employee of LHH / MEETH? ☐ Yes ☐ No

Religion

Advance Directives:
☐ Yes (Provide Copy) ☐ No
Type: ☐ Healthcare Proxy
☐ Living Will
☐ Do Not Resuscitate
☐ Other: ______________
Specify

Do You Carry An Organ Donors Card? ☐ Yes ☐ No

Occupation

Employer

Employer Address
Street

City State Zip

Length of Service With Current Employer Years Months

Employer's Phone ( )

EMPLOYMENT STATUS
☐ Employed ☐ Disabled
☐ Unemployed ☐ Retired

ACCIDENT INFORMATION **IF THIS ADMISSION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION IN FULL**

Type of Accident: ☐ Work Related ☐ Auto ☐ Home ☐ School ☐ Other **Date of Accident:** Month | Day | Year

Time of Accident: ☐ AM ☐ PM **Location of Accident:** Street City State Zip

PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS

Name of Person on Insurance Card Last First **Relationship to Patient**

Name Last First

Address Street Apt # City Zip

County of Residence **Phone # ( )** **Social Security #** — —

Employment Status ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired **Sex** ☐ Male ☐ Female **Birth Date**

Occupation **Employer**

Employer Address Street City State Zip **Phone ( )** **Ext:**

PERSON TO CONTACT IN AN EMERGENCY **Relationship to Patient** ______________

Name: Last First **Address:** Street City Apt # State Zip

Home Phone: ( ) Work Phone: ( ) Ext:

IF PATIENT IS 18 OR UNDER (25 IF STUDENT) ENTER OTHER PARENT INFORMATION BELOW.
IF PATIENT IS MARRIED ENTER SPOUSE INFORMATION. OTHERWISE ENTER CLOSEST RELATIVE.

LEGAL NEXT OF KIN **Relationship to Patient** ______________ **Date of Birth** ______________

Name: Last First **Address:** Street City Apt # State Zip

Home Phone: ( ) Work Phone: ( ) Ext:

MISCELLANEOUS **Have you ever been an inpatient at Lenox Hill Hospital / MEETH?** ☐ Yes ☐ No

If yes, under what name? ______________ **Dates: From:** Mo | Dy | Yr **To:** Mo | Dy | Yr

Have you been an inpatient in another Hospital or Skilled Nursing Facility within the last 60 days? ☐ Yes ☐ No

If yes, under what name? ______________ **Dates: From:** Mo | Dy | Yr **To:** Mo | Dy | Yr

Name of Institution: ______________

LenoxHill Hospital

FORM B REGISTRATION

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to **866-219-5545**

☐ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to **866-231-1027**

Date of Surgery: ________ / ________ / ________

Patient Name: ____________________

Physician's Name: ____________________

INSURANCE INFORMATION PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW FOR BOTH PATIENT AND SPOUSE, OR BOTH PARENTS IF PATIENT IS 21 OR UNDER . . . **AND ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARDS.**

MEDICARE

Name of Beneficiary

Claim Number Sex

Is Entitled To Effective Date

Hospital (Part A)

Hospital (Part B)

OTHER BLUE CROSS

BLUE CROSS/BLUE SHIELD OF ____________________
STATE

SUBSCRIBER'S NAME ____________________

IDENTIFICATION ____________________

MEDICARE PATIENTS OR SPOUSE

ARE YOU RETIRED? ☐ YES ☐ NO
IS YOUR SPOUSE RETIRED? ☐ YES ☐ NO

DATE OF RETIREMENT PATIENT
SPOUSE

DO YOU HAVE OTHER INSURANCE? ☐ YES ☐ NO

IF SPOUSE IS EMPLOYED, PLEASE PROVIDE HIS/HER INSURANCE INFORMATION ON THIS FORM.

OTHER INSURANCE (HMO, UNION, TRAVELERS, METROPOLITAN, ETC.)

Name on Card LAST ____________ FIRST ____________

Policy Number ID # ____________ GRP # ____________

Payor ID Number ____________________

Group Name ____________________

• Employer Name ____________________
AS IT APPEARS ON THE CARD

Address ____________________

____________________ Phone

Insurance Company Name ____________________

Address ____________________

____________________ Phone

WORKERS COMP (ATTACH AUTHORIZATION FORM)

INSURANCE COMPANY NAME ____________ ADDRESS ____________ PHONE ( ) ____ – ____

EMPLOYER NAME ____________ ADDRESS ____________ PHONE ( ) ____ – ____

WCB # ____________ Accident Date ____ / ____ / ____ Accident Time ____________ ☐ AM ☐ PM Claim Filed: ☐ Yes ☐ No

NO FAULT (ATTACH FORM FROM INSURANCE COMPANY)

INSURANCE COMPANY NAME ____________ ADDRESS ____________ PHONE ( ) ____ – ____

CAR OWNER NAME ____________ ADDRESS ____________ PHONE ( ) ____ – ____

INSURANCE AGENT OR ATTORNEY NAME ____________ PHONE ( ) ____ – ____

ACCIDENT DATE ____ / ____ / ____ Accident Time ____________ ☐ AM ☐ PM POLICY NO. ____________ FILE NO. ____________

MEDICAID

NAME ON CARD LAST ____________ FIRST ____________

ID NUMBER ____________________

ISO # ____________ ACCESS NUMBER ____________ SEQ # ____________

☐ **SELF PAY/UNINSURED**

FORM C

Lenox Hill Hospital

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to **866-219-5545**

☐ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to **866-231-1027**

PATIENT QUESTIONNAIRE

Patient Name:

Surgeon:

Planned procedure: ________________________________

Please list ALL PAST SURGERIES:

____

____

____

ANESTHESIA problems: ☐ Yes ☐ No

If Yes, please list:

____

Please list ALL MEDICATIONS, including DOSAGE :

____

____

____

____

____

____

List any ALLERGIES (medications/food/inhalant):

____

____

Do you smoke? ☐ Yes ☐ No

Did you previously smoke? ☐ Yes ☐ No

Packs per day:__________ for ___________ years Quit_________

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per week ____________

Do you use recreational drugs? ☐ Yes ☐ No

Please List _______________________ How often____________

Please list any non-prescription medications:
(e.g. cold tablets, vitamins)

____

____

Please list any HERBAL:
(e.g. Cava-Cava, Ginkgo, Ginseng, St. John's wort, Echinacea)

____

____

Please check any symptoms you have recently experienced:

☐ Fever / chills	☐ Weight loss
☐ Weakness	☐ Fatigue

☐ Pain (identify location):________________________________

Please list ALL YOUR medical conditions:

☐ Anxiety	☐ Kidney disease
☐ Arthritis	☐ Liver disease
☐ Asthma	☐ Pacemaker
☐ Bleeding problems	☐ Palpitations/irregular heart
☐ Bronchitis	☐ Pneumonia
☐ Chest pain	☐ Reflux
☐ COPD	☐ Seizure
☐ Depression	☐ Shortness of breath
☐ Diabetes	☐ Sickle cell
☐ Excessive bruising	☐ Sleep apnea
☐ Glaucoma	☐ Stroke
☐ Heart Attack	☐ TB
☐ Heat/Cold problems	☐ Thyroid disease
☐ Hiatal hernia	☐ Ulcer
☐ High blood pressure	☐ Urinary problems

Family History of Medical Conditions:

☐ Asthma	☐ Heart
☐ Cancer	☐ High blood pressure
☐ Diabetes	☐ Stroke
☐ Emphysema	☐ Other:___________

List your primary care physician:

Name:________________________________

Address:________________________________

____

Telephone:________________________________

Date:________________________ Patient Signature:________________________________

Staple

LenoxHill Hospital

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Surgical Cases Fax to **866-231-1027**

FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

DATE OF SURGERY:__________________ PATIENT NAME:____________________________________ D.O.B.:________________

PLANNED PROCEDURE:____

History of Present Illness

____

____

____

____

____

Past Medical History	Yes	No		Yes	No		Yes	No		Yes	No
Hypertension	☐	☐	Angina	☐	☐	Liver Disease	☐	☐	Blood clots	☐	☐
Diabetes	☐	☐	Stroke/TIA	☐	☐	Thyroid disease	☐	☐	Bleeding problems	☐	☐
Myocardial Infarction	☐	☐	Lung disease	☐	☐	Kidney Disease	☐	☐	Blood transfusions	☐	☐

Other/Explanation for Positive History:____

____

____

Past Surgical History

____

Advanced Directive ☐ Yes ☐ No__________________________ Health Care Proxy ☐ Yes ☐ No________________________

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER THE COUNTER AND HERBAL MEDICATIONS.

Medication Name	Dose (mg, mcg)	Route (PO, GT, SC, IV)	Frequency

*If more space is required continue on progress note

Review of Systems	Neg	Positive (*Check if positive*)
Constitutional	☐	☐ Anorexia ☐ Fatigue ☐ Fever ☐ Weight loss
Cardiovascular	☐	☐ Angina ☐ DOE ☐ Orthopnea ☐ Edema ☐ Palpitations ☐ Syncope
Respiratory	☐	☐ Cough ☐ Dyspnea ☐ Pleuritic chest pain ☐ Other_______________
Gastrointestinal	☐	☐ Stomatitis ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Dysphagia
Genitourinary	☐	☐ Dysuria ☐ Frequency ☐ Incontinence ☐ Hematuria ☐ Impotence
Neurologic	☐	☐ Paresthesia ☐ Dysesthesia ☐ Headache ☐ Seizure
Skin	☐	☐ Rash ☐ Ulcers ☐ Other____________________________
Hemorrhage	☐	☐ Easy bruising ☐ Epistaxis ☐ Hemoptysis ☐ Hematochezia ☐ Melena
Endocrine	☐	☐ Polyuria ☐ Polydipsia ☐ Heat/Cold Intolerance
Psychiatric	☐	☐ Depression ☐ Hallucinations ☐ Sexual dysfunction
Musculoskeletal	☐	☐ Joint pain ☐ Back pain
Eyes/Ears	☐	☐ Decreased hearing ☐ Decreased vision
☐ Other		

Allergies____

____

History of anesthesia reaction: ☐ Y ☐ N

____

____

Family History_______________________________

____

____

____

____

Social History

Tobacco______________________________________

Alcohol______________________________________

Drugs_______________________________________

Other_______________________________________

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☐ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to **866-231-1027**

FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

Patient Name:________________________________ DOB:______________ MR #:_______________ Acct #:_______________

OB/GYN History (Not Applicable ☐):

Age of menarche_________ Date of LMP_________________ Age of Menopause_________ Gravida_________ Para_________

Miscarriage(s)____________ Abortion(s)____________ Age at First Pregnancy____________ Age at Last Pregnancy ___________

Use of Oral Contraceptives: ☐ Yes ☐ No Age began oral contraceptives___________ Duration_____________________________

Mammogram ☐ Yes ☐ No _________________________ PAP Smear ☐ Yes ☐ No ___________________________

PHYSICAL EXAMINATION

Height:	Weight:	BP:	P:	T:	R:	Pain (0-10):	BMI:

	NL	ABNL	Explanation
General	☐	☐	
Skin	☐	☐	
Neck	☐	☐	
HEENT	☐	☐	
Cardio	☐	☐	
Chest/Lung	☐	☐	
Abdominal	☐	☐	
Ext	☐	☐	
Neurologic	☐	☐	
Nodes	☐	☐	
Breasts	☐	☐	
Deferred ☐	☐	☐	
Rectal/Genital/Pelvic	☐	☐	
Deferred ☐	☐	☐	
Other (Specify)			

Significant Labs/X-rays/Exam Diagram

Labs	NL	ABNL
CBC	☐	☐
CHEM	☐	☐
PT/PTT	☐	☐
UA	☐	☐
Other	☐	☐
CXR	☐	☐
EKG	☐	☐
Other (i.e. Stress test, Labs, Endoscopy, Etc.)	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐

DIAGNOSIS ____

No medical contraindications to proposed surgery ☐ Yes ☐ No____

Examining Provider___________ Lic. #___________ Address_________________________ Phone___________ Fax___________

MD Stamp

MD Signature: ________________________________ Date: _____________

SURGEON ASSESSMENT / PLANNED PROCEDURE

____

____

FOR AMBULATORY/SDA SURGICAL/INVASIVE PROCEDURES (to be completed day of procedure):
The patient has been examined and the History and Physical has been reviewed. There are no significant changes in the patient's condition condition unless noted below.

____

Signature:MD/DO (NP, House Physician, or Resident for podiatry or dental cases)

Print Name:____ MD/DO/NP Time/Date:_________________

For Podiatry and Dental patients only: I have reviewed the H&P including the update.

Signature:____ MD/DO/NP Time/Date:_________________

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FORM D
PRESURGICAL - HISTORY & PHYSICAL EXAM FORM

PRE-OPERATIVE TESTING - PHYSICIAN GUIDELINES

The following list does not preclude request for tests if deemed appropriate by the surgeon. Provided there is no change in the patients condition that warrants repeat testing, diagnostic tests are valid as follows:

Chest X-rays are acceptable for up to 12 months EKG results for up to 60 days	Laboratory results up to 30 days except Pregnancy Test Type and Crossmatch up to 3 days	If transfusion or pregnancy within 3 months, Type and Crossmatch valid for 72 hours

PRETESTING ORDERS (The appropriate items will necessitate the ordering of tests that appear in the parentheses.)

Condition

- Cardiovascular Disease or High Risk for CV Disease (Hgb, Na, K, Cl, CO2, Bun/Creat, EKG, Chest X-Ray)
- Pulmonary disease (CBC, Chest X-Ray, EKG)
- Malignancy - (CBC, Platelet Count, PT/PTT, Na, K, Cl, CO2, Bun/Creat, LFT, EKG, Chest X-Ray)
- Bleeding Disorder (Hgb, Platelet Count, PT/PTT)
- Smoking > 20 pack years (Hgb, Chest X-ray, EKG)
- Cardiac Surgery/Interventional/Vascular Surgery (CBC, EKG, SMA2O, CPK, PT/PTT, Type & Crossmatch, Magnesium, Fibrinogen, Chest X-ray, PA Lateral)
- Diabetes (Chem-7, EKG)
- Renal Disease (Hgb, Na, K, Cl, CO2, Bun/Creat, EKG)
- Hepatobiliary Disease (PT/PTT, Chem-7, Liver Function)

Medication Use

- Diuretic use (CBC, Na, K, Cl, CO2, Bun/Creat, EKG)
- Digoxin use (CBC, Na, K, Cl, CO2, Bun/Creat, EKG)
- Steroid use (CBC, Chem-7)
- Anticoagulants (Hgb, Platelet count, PT/PTT)

Other

- Urinalysis/Urine Culture and Screen
- Type & Screen
- Chest X-ray, PA & lateral
- Expected blood loss of 2 or more units (Hgb,Type and crossmatch)
- Male > 45 yr. Or Female > 50 yr. (EKG)
- If LMP < or = to 1 year (Pregnancy Test)
- Thyroid Function test
- Tumor Markers

If stress test positive then Echo and/or Cath. Lab report (attach results)

Do Not Fax Back

North Shore LIJ Lenox Hill Hospital
100 East 77th Street, New York, NY 10075-1850
210 East 64th Street, New York, NY 10065-7471

CONSENT TO SURGICAL PROCEDURE, INVASIVE TEST, PROCEDURE, TREATMENT and/or ANESTHESIA

I hereby authorize Dr. ______________________________ and his/her associates or assistants to perform upon the named patient or me the following surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s):

____

____

including such photographing, videotaping, televising or other observation of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

The purpose of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) has/have been explained to me and I have also been informed of the expected benefits and possible complications, attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) that unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) which the above-named physician or practitioner or his/her associates or assistants may consider necessary.

I consent to the release of my social security number to the manufacturer of any device that is surgically implanted in me during my admission. I understand release of my social security number is for the purpose of helping the manufacturer locate me if there is a need to contact me with regard to the implanted medical device.

I further consent to the administration of blood transfusion(s) during surgery and during the Recovery Room period as may be considered necessary. I recognize that there are always risks to life and health associated with blood transfusion(s) and such risks have been fully explained to me. The benefits of blood transfusion(s) and alternatives to their use have also been explained to me.

I understand that the use and type of anesthesia, sedatives or analgesics which may be considered necessary will be explained to me by the Anesthesiologist before surgery or by the physician or practitioner administering the medication prior to any surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s). The risks, benefits and alternatives to their use will also be explained to me.

I understand any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the surgical procedure(s)/invasive test(s)/procedure(s) and/or 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 or words above, which do not pertain to me.

Patient/Healthcare Agent/Guardian/Next-of-kin: ______________________________
Signature — Patient's SS#

____
Print Name — Date/Time

Relationship (if signed by other than patient): ______________________________

Witness: ______________________________
Signature — Print Name — Date/Time

Interpreter: ______________________________
Signature — Print Name — Date/Time

Physician/Practitioner Certification

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) and blood transfusion(s) have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: ______________________________
Signature/Title — Print Name — Date/Time