ATTENTION

Consent Forms Need Signature

PATIENT: _____ MEDICAL RECORD #_____

DATE: _____

AUTHORIZATION FOR TREATMENT

1. I, the undersigned, do hereby agree and consent to the treatment of the patient named above to Hospital and I hereby request and authorize_____Hospital, the members of the Medical and Nursing Staff and their designees to provide such care and administer such diagnostic, and/or therapeutic procedures and treatments as, in the judgement of the physician(s) is deemed necessary or advisable. For obstetrical service, this includes care of the newborn.

2. This consent includes authorization for all routine diagnostic tests, and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications. I acknowledge the fact that the hospital has the authority to dispose of specimens taken for laboratory or pathology examination.

3. The Hospital provides only general duty nursing care. If the patient is in such condition as to need continuous or special duty nursing care it is agreed that such care will be arranged for by the patient, his/her legal representative, or his/her physicians(s) and that the hospital is in no way responsible for failure to provide the same.

4. I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatment or examination done in the hospital.

If a patient requires a surgical operation and/or procedure, Form #M-322A, Authorization For Surgical Treatment must also be signed by the patient or by the person who stands for the patient.

Surgery is likely to result in sterilization, signature of the patient must be secured on Form #M-202A or B, Authorization for Sterilization Operation in addition to this consent.

Refusal for any services named on the consent Form requires notification to the Surgeon prior to any procedures being performed. I understand I can change my mind and withdraw my consent at any time prior to surgery of procedure(s) performed.

PATIENT RIGHTS AND ADVANCE DIRECTIVES

Hospital patients have specific rights under state and federal laws. I have received a copy of the Patient's bill of Rights as required by New York Sate law, and have had an opportunity to receive assistance in understanding and exercising these rights. My signature also acknowledges my receipt of "An Important Message From Medicare."

PERSONAL BELONGINGS

I have been informed that_____Hospital maintains a sage for the safekeeping of money, personal effects and other valuables. Understanding that any items not deposited with the hospital have the potential to become lost or misplaced. I hereby release the hospital from any and all liability resulting from the loss or disappearance of said items. Any personal property, listed below, which I keep with me at the hospital, shall be at my own risk and_____Hospital shall not be liable for any loss or damage to it.

Items Kept With Patient

_____ _____ _____

Signed: _____ or _____
Patient Authorized Representative

_____ _____

Witness Relationship to Patient

– OVER –

Record of Attempts To Inform Authorized Representative of Admission/Need for Signature

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

Auth. Repres. _____	Auth. Repres. _____	Auth. Repres. _____
☐ INFORMED	☐ INFORMED	☐ INFORMED
☐ UNABLE TO REACH	☐ UNABLE TO REACH	☐ UNABLE TO REACH
☐ MESSAGE LEFT	☐ MESSAGE LEFT	☐ MESSAGE LEFT

SIGNED: _____	SIGNED: _____	SIGNED: _____
Emergency Room	Floor Nurse	Case Coordinator