AABP
INTEGRATIVE PAIN CARE

192 E Shore Rd,
Great Neck, NY 11023
Phone: 516-482-7246
Fax: 516-482-1433

Patient Name: _____
DOB: _____

Consent to Surgical Procedure, Invasive Test, Procedure, Treatment and/or Anesthesia

I hereby authorize Dr. _____ and or such assistant(s) 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 not to treat. The attendant risks of no treatment have also been discussed. I have been given the 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 further consent to the administration of Volume Expanders during the procedure and during Recovery Room period as may be considered necessary. I recognize that there are always risks to life and health associated with Volume Expanders and such risks have been explained to me. The benefits of Volume Expanders and alternatives 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 the procedure 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 risk, benefits and alternatives to their use will also be explained to me.

I acknowledge that no guarantee or assurance 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-to-Kin: _____
Relationship: _____ Contact Information: _____
Witness: _____

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

Physician/Practitioner: _____ Date: _____
Interpreter (if required): _____
Witness: _____