

- Rochester General Hospital
- Newark Wayne Community Hospital
- DeMay Living Center
- Other _____

Addressograph/Name & DOB

PROCEDURE AUTHORIZATION FORM

I, (print name) _____ for _____, hereby authorize

Dr. _____ to perform the following treatment/procedures:

1. The provider responsible for my care has explained to me in a manner which I understand, the nature of my (my child's) ailment, my (my child's) need for treatment as well as the proposed procedure(s) identified above including associated care, treatment, services, and/or medications. My provider has answered all my questions to my satisfaction.
2. My provider has explained to me the benefits, risks or side effects and alternatives, including no treatment at all, the likelihood of success and problems related to recuperation of the proposed procedure(s) and alternatives. I also understand that there are other less common risks for the procedure(s) and related care that have not been explained but may be explained at my request. My provider has explained the likelihood of achieving goals and that all procedures involve a certain amount of risk and that no procedure guarantees improvement of my ailment (condition).

For authorizations with attached page(s): I understand the specific benefits, risks or side effects and alternatives as listed on the attached page. (Sign any additional page.)

3. I hereby give my provider, together with such assistants/associates/student in a hospital approved program as may be selected by him/her, with my informed consent for the above procedure(s).

Following clauses 4 through 8 may not be applicable for procedures done in an area other than the Operating Room. Check N/A if not applicable.

4. If the nature of the procedure(s) requires an anesthesiologist or a certified registered nurse anesthetist, I consent to the administration of anesthesia to be administered under the direction of a member of the Department of Anesthesiology (see list of members on back).
N/A
5. I authorize a member or members of the Department of Pathology to examine and dispose of any tissue(s), organ(s) or implants removed as a result of the procedure(s) authorized above, or to preserve such tissue(s), organ(s) or implants at its discretion for scientific or teaching purposes.
N/A
6. I understand that, as part of the process of using new products or technology, technical consultants, who have been approved by my provider and the hospital, may be in attendance as an observer during my (my child's) procedure(s) treatment. I consent to such an observer being present.
N/A
7. I further authorize the provider responsible for my (my child's) care to carry out whatever additional procedure(s) or method(s) of treatment he/she may deem necessary if unforeseen conditions may be involved that necessitate an extension of the original procedure or a procedure that is different from the procedure identified above including administration of blood and/or blood products during the peri-operative period.
N/A
8. I consent to photographing and/or videotaping of the procedure for medical, scientific, or educational purposes provided that my (my child's) identity is not revealed. The prints or negatives, and/or the videotapes are the property of the hospital or the provider. I waive all rights of ownership or payment of any kind in connection with the prints, negatives, or videotapes and understand that they will not be made available to me (my child) under any circumstances.
N/A

Patient Signature: _____ Signature of Parent or Guardian: _____

Other: _____ Relationship: _____

Witness: _____ Date: _____ Time: _____

Witness Signature only needed if pt/legal rep. unable to sign name

OVER →



Grp & Account# BARCODE



DocType BARCODE

PROCEDURE AUTHORIZATION, continued

Patient Name _____

Birth Date _____

NIDRC# _____

Account# _____

ATTESTATION OF INFORMED CONSENT: *Prior to procedure or administration of blood/blood products, or moderate sedation*

The risks, benefits and alternatives to the planned procedure(s), as well as the identity of any additional physicians, podiatrists or dentists involved in the procedure, treatment or surgery, have been discussed with the patient and/or surrogate, and/or proxy.

Yes No Not Applicable

The use, risks, benefits and alternatives of blood or blood products have been discussed with the patient and/or surrogate and/or proxy.

Yes No Not Applicable

The use, risks, benefits and alternatives to the possible use of moderate sedation agents have been discussed with the patient and/or surrogate, and/or proxy.

Yes No Not Applicable

Provider's Signature: _____ Date: _____

ANESTHESIA DEPARTMENT

Richard Allen, CRNA

John Barbaccia, M.D.

Hugh Brodie, M.D.

Robert Cafarelli, M.D.

Michael Carafos, M.D.

Frank Catanzaro, M.D.

Stephen Comella, M.D.

Dominick Cortese, M.D.

Michael DeTraglia, M.D.

Eric Dotson, M.D.

Duncan Douglas, M.D.

Steve Fezer, CRNA

Steve Giriappa, M.D.

Jill Glunz, CRNA

Paul Guadagnino, M.D.

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Jay Jayadeva, M.D.

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Gassem Oskoui, M.D.

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