Rochester General Health System

- ❑ Rochester General Hospital
- ❑ Newark Wayne Community Hospital
- ❑ DeMay Living Center
- ❑ Hill Haven Nursing Home
- ❑ Independent Living for Seniors
- ❑ Rochester Mental Health Center

Patient Name

AUTHORIZATION FORM (Informed Consent)

I, (*print name*) _____ for _____, hereby authorize Dr. _____ to perform the following treatment/procedures:

_____

1. My provider 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 have been informed of and I hereby give my provider, together with such assistants/associates/students in a hospital approved program as may be selected by him/her, my informed consent for the above procedure(s).
4. 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 when unforeseen conditions become involved that necessitate an extension of the original procedure or a procedure that is different from the procedure identified above.

Following clauses 5 through 8 may not be applicable for procedures done in an area other than the Operating Room. Check N/A if not applicable.

5. ☐ N/A 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).*
6. ☐ N/A 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.
7. ☐ N/A 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.
8. ☐ N/A 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.

Patient Signature: _____ Signature of Parent or Guardian:_____

Other: _____ Relationship: _____

*** Witness: _____ Date:_____ Time: _____**

I have provided the patient/legal representative with information pertaining to the proposed treatment/procedure, its reasonably foreseeable risks, benefits and alternatives. I have answered all of the patient's/legal representative's questions.

Signature of Provider who obtained informed consent:_____

Date:_____ Time: _____

*Witness signature needed if pt./legal representative unable to sign name

OVER ⟹

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Patient Name

Blood/Blood Products AUTHORIZATION FORM (Informed Consent)

I, (*print name*) _____ for _____, hereby authorize the following provider: _____ to transfuse me (my child) with:

☐ A series of blood or blood product

☐ A single course of blood or blood product

1. My provider has explained to me in a manner which I understand, my (my child's) need for blood/blood products and 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 blood or blood products at all, the likelihood of success and problems related to my (my child's) condition. My provider has explained the likelihood of achieving goals and that any blood or blood product transfusion involves a certain amount of risk and that no procedure guarantees improvement of my ailment (condition).
3. I have been informed of and I hereby give my provider, together with such assistants/associates/students in a hospital approved program my informed consent for the above checked blood or blood product transfusion.

Patient Signature: _____ Signature of Parent or Guardian:_____

Other: _____ Relationship: _____

*** Witness: _____ Date:_____ Time: _____**

I have provided the patient/legal representative with information pertaining to the proposed treatment/procedure, its reasonably foreseeable risks, benefits and alternatives. I have answered all of the patient's/legal representative's questions.

Signature of Provider who obtained informed consent:_____

Date:_____ Time: _____

*Witness signature needed if pt./legal representative unable to sign name

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When anesthesia is indicated, the following is a list of providers who are privileged to administer anesthesia as of 8/12/10.

Allen	Richard	C.	CRNA	Marin	Ernesto	L.	MD
Barbaccia	John	J.	MD	Mauro	Salvatore		MD
Baronos	Eleftherios	S.	MD	Mogan	Jennifer	L.	MD
Brodie	Hugh	M.	MD	Mulbury	Michael	J.	MD
Cafarell	Robert	F.	MD	Narayan	Kariappa		MD
Carafos	Michael	A.	MD	Nemani	Ajai	K.	MD
Catanzaro	Frank	A.	MD	Patel	Chirag	R.	MD
Chin	Melvyn	J. Y.	MD	Patel	Harshadrai	C.	MD
Comella	Stephen	G.	MD	Perez-Johnson	Christie	M.	MD
Cortese	Dominick	A.	MD	Prairie	Lyle	J.	MD
Cross	Paul	A.	DO	Proper	Gilbert	P.	MD
DeTraglia	Michael	C.	MD	Rayfield	Mary	E.	CRNA
Dotson	Eric	D.	MD	Rosenburg	Jeffery	A.	MD
Douglas	Robert	D.	MD	Ruffo	Daniel		CRNA
Fegley	Allison	J.	MD	Sanfilippo	Angelo	D.	MD
Fezer	Stephen	J.	CRNA	Slomovic	Lorraine		CRNA
Giriyappa	Sudhir		MD	Szalados	James	E.	MD
Glunz	Jill	G.	CRNA	Szczurek	Roberta	C.	MD
Green	Donald	R.	MD	Taylor	David	A.	MD
Guadagnino	Paul	L.	MD	Tonetti	John	E.	MD
Hans	Anthony	L.	MD	Turk	Dru	H.	MD
Kendall	Jennifer		MD	Villareale	Michael	E.	MD
Kieran	Tamara		CRNA	Wasserman	Jeffrey	A.	MD
Kleene	Bruce	M.	MD	Young	Robert	J.	MD
Korten	Santiago	E.	MD	Zhavoronkov	Ilya	G.	MD
Lanni	Alan	F.	MD	Zigarowicz	Georgianne		MD