



**CONSENT FOR PAIN PROCEDURE OR
REGIONAL ANESTHESIA**

I request and consent to a regional anesthesia/pain procedure called _____
(Practitioner must fill in complete name of procedure)

and I understand that the purpose of this procedure is _____
(Practitioner must describe procedure in non-medical terms)

This procedure will be performed by _____ and/or
his/her associate(s) and any assistants he/she designates.

I have been advised that this procedure may have potential benefits, risks, or side effects associated with it, including, but not limited to: bleeding, infection, failure to achieve expected result, pain, nerve damage/paralysis, potential injury to a limb while numb, headache, backache, allergic reactions, toxic drug reactions which may cause seizures, and damage to any and all surrounding tissue, including potential problems that might occur during recuperation.
I have been advised of the alternatives, the risks, benefits and side effects related to alternatives.

I understand that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment.

I understand that portions of the operation may be photographed or videotaped. I consent to this as long as my identity is not revealed. I understand that these photographs may be used for teaching. I also understand that residents, medical, nursing and allied health students/trainees may be present during the procedure and they may observe or assist in my care, under the direction of my surgeon and other hospital staff members.

I understand that in the event one or more of my health care providers sustains a needlestick/sharp injury or exposure to my blood/bodily fluids that blood may be drawn and may be tested for hepatitis and the result of that hepatitis testing disclosed to the health care providers who sustained the exposure.

I also understand that a sales/clinical representative may be present during the procedure, but may not participate in the procedure.

I impose no specific limitations or restrictions on my treatment other than:

(Patient must specify restriction or write "None")

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of this treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. All blank spaces are completed or lined out, prior to my signing this document.

_____ Signature of Patient, Parent, Guardian, Health Care Agent or other representative of patient	_____ Relationship (if other than Patient)	_____ Date	_____ Time
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_____ Signature of Witness (Age 18 or older, other than Practitioner performing this procedure)	_____ Title or Relationship to Patient	_____ Date	_____ Time
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An interpreter or special assistance was used to obtain consent from this patient. _____
(Name of Interpreter)

I verify that I have explained the procedure, relevant risks, benefits and alternatives, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services.

_____ Signature /ID # of Practitioner	_____ Date	_____ Time
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AS2C011

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PHYSICIAN VERIFICATION (Check all that apply)

PART A. ASSESSMENT AND REASSESSMENT OF PATIENT

(ONLY Out Patient/Same Day Surgical and Invasive Procedures MUST have the History and Physical examination completed within 30 days, updates within 24 hours of surgical/invasive procedure)

I verify that I have reviewed this consent and confirm the accuracy of the document including the description of the procedure. I have reviewed the operative/procedural plan with the Anesthesiologist and the Nursing staff. I have reassessed and updated the patient's current condition, and/or completed a new History and Physical, and determined this specific operation/procedure is indicated at this time.

PART B. SURGERY/PROCEDURE SIDE/SITE VERIFICATION

ATTENDING SITE/SIDE VERIFICATION

I have marked the site(s) and side(s) of surgery as required by Stony Brook University Medical Center policy.

OR

The site/side marking(s) of the _____ as required by Stony Brook University Medical Center policy could not be done for the following reason(s) _____

Attending Performing Surgery/Procedure Signature ID# Date Time

ANESTHESIOLOGY SITE/SIDE VERIFICATION (When present)

I confirm that I have verbally verified the correct operative/procedural site/side with the patient. If the **patient's** status prohibits verbal verification of correct site/side, **verification** obtained utilizing the medical record.

Attending Anesthesiologist Signature ID# Date Time

NURSE SITE/SIDE VERIFICATION

I confirm that I have identified the operative site/side and that the patient is marked or an exception was documented as above. There is oral agreement among the attending performing the operation/procedure, the anesthesiologist and myself.

Nurse Signature ID# Date Time

****Documentation of the Time Out Process is noted in the Intra-Operative Nurses Record or Procedure Note.***

An interpreter or special assistance was used to verify site/side verification from this patient

(Name of Interpreter)