CARDIOSMART PLLC
Road to a healthy heart

Cardiosmart PLLC
Bayside Cardiac Care
216-16 Union Turnpike,
Bayside, New York 11364
Phone: (718) 465-4000 | Fax: (718)-776-6823
www.BaysideCardiacCare.com

Location:
☐ 216-16 Union Turnpike, Bayside ☐ 266-19 Union Turnpike, Queens ☐ 207-07 Hillside Avenue, Queens

NAME: _____ **DOB:** _____

MRN: _____

CONSENT FOR DIAGNOSTIC PROCEDURE

Permission: I hereby authorize Dr. _____ and his/her associates or assistants who are _____(MD,PA, NP, RN, MA) at Cardiosmart PLLC, Bayside Cardiac Care to perform the following procedure(s): (*procedure to be written both in medical terminology and in terms that the patient can understand*).

STRESS ECHO

Explanation of procedure(s), risks, benefits and alternatives: Dr. _____ has fully explained to me the nature and purpose of the procedure(s) and also informed me of expected benefits and complications (from known causes), attendant discomforts and the risks that may arise, as well as possible alternative methods of diagnosis and/or treatment to the proposed procedure(s), including no treatment. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily.

Understanding of this form: I confirm that I have read this form, fully understand its contents and that all blank spaces above have been completed prior to my signing. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s) described above.

_____ _____
Patient/Agent/Relative/Guardian* Signature Date Print Name Relationship if other than patient

_____ _____
Interpreter, if required Signature Date Print Name

_____ _____
Witness to signature Signature Date Print Name

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner's Certification. I hereby certify that I have explained the nature, purpose, benefits, complications from, risk of, alternatives to (including no treatment and attendant risks), and the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I further certify that the **"Permission"** section of this form accurately identifies the proposed procedure. If applicable, I certify that outside pathology slides have been reviewed by the Pathology Department at North Shore University Hospital.

_____
Provider's Signature Date