CONSUMER ADVISORY BOARD
WILLOWBROOK CLASS
1050 FOREST HILL ROAD
STATEN ISLAND, NY 10314
(718) 477-8800 FAX (646) 766-3488

Medical Consent Overview

[Attach all applicable consults.]

Class member name: _____ DOB: _____ Age: ____

Home Address: _____

Primary Health Services Contact: _____

Telephone: Day _____ Evening _____

Secondary Contact: _____
Telephone: Day _____ Evening _____

Is an Expedited Review Necessary? ____ Yes ____ No
If an expedited review (within 8 business days after CAB receipt) is requested, please explain the medical circumstances:

ALL QUESTIONS MUST BE ANSWERED TO PREVENT UNNECESSARY DELAYS.

Recommended Procedure [Attach all applicable consults]: _____

Description of procedure:

Reason for procedure:

Risks & Benefits:

Type of Sedation/Anesthesia: ☐ Oral [PO] ☐ Local ☐ Intravenous [IV]
☐ Monitored Anesthesia Care [MAC] ☐ General Anesthesia [GA]
☐ Other [specify] _____

Explain

Risks & Benefits:

Second opinion: ☐ Yes ☐ No **Date Obtained: _____**
Physician: _____ Telephone: _____

[*Attach all applicable consults.*]

Is there an alternative procedure: ☐ Yes ☐ No

If yes, state the procedure, explain the risks/benefits and why this is not the preferred option:

Medical History:

Current Medications:

Allergies (food and/or medication) : ☐ Yes ☐ No If yes, list

Previous invasive procedures with date/results/complications [related or unrelated]:

Physician: _____ Telephone: _____

Primary Physician: _____ Telephone: _____

Is there family/guardian: ☐ Yes ☐ No Is there a health care agent: ☐ Yes ☐ No

If yes to either of the above, explain:

Local CAB Representative: _____

Provide dates of all contacts with the local CAB representative in regard to this proposed medical procedure:

Return address for signed consent(s):

Submitted by Name/Date/Phone: _____

Reviewed by Name/Date/Phone: _____

CAB Use Only:
Date _____
Initial _____

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