



Mount Sinai Health System

New York

CONSENT TO SURGERY/PROCEDURE/ TREATMENT AND ANESTHESIA



Name, DOB, MRN fields

1. I hereby authorize ... and ... and those associates or assistants designated to perform upon ... the following treatments, surgeries, procedures (referred to as "Procedure") to include:

A team of medical professionals will work together to perform my Procedure. My Attending Physician/Privileged Provider, or other Designated Privileged Provider, will be present for all critical parts of the Procedure.

- 2. The Attending Physician/Privileged Provider above ... has fully explained to me, in my preferred language what will happen during and after my care...
3. I understand that during the course of the above proposed Procedure something unexpected may come up...
4. I understand that my medical professional may provide me with medications to keep me comfortable and safe...
5. If applicable, I agree that I may need blood or blood product transfusions...
6. If applicable, I agree that organs, tissues, implants, or other body fluids may be removed...
7. If applicable, I agree to allow the recording of images and sound of this Procedure...
8. If applicable, I agree to allow authorized observers into the operating or treatment room.
9. I have marked the portions of the document I do not agree to.

Patient,* Guardian or Representative**

Print name, Signature, Date, Time, Relationship or "self"

Signature Witness

Print name, Signature, Date, Time, Witnessed Patient confirming signature (check box if applicable)

Preferred Language Interpreter

Name or Number, Print name and/or number, Signature (if present), Date, Time, Patient refused interpreter (check box if applicable)

Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative**/Interpreter signature not required.

The Attending Physician or Privileged Provider who is performing the procedure must sign the certification below.

I, the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have been explained to the patient/guardian/representative** and I have offered to answer any questions and have fully answered all such questions.

Print name, Attending Physician/Privileged Provider Signature, Date, Time

If more than thirty days have passed since this consent form was signed or the consent conversation was held:

I, the Attending Physician or Privileged Provider, have reaffirmed the patient/guardian/representative's** understanding and certify that there has been no substantial change to the patient's condition in the time period since the consent form was signed.

Print name, Attending Physician/Privileged Provider Signature, Date, Time

* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.

** Throughout this document, the term "representative" refers to a legally authorized representative.

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.



Mount Sinai

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New York

CONSETEMENT POUR INTERVENTION
CHIRURGICALE/PROCEDURE/THERAPIE
ET ANESTHESIE



Name
DOB
MRN

1. Par les presentes, j'autorise et et les associes
ou assistants designes a administrer a/effectuer sur les therapies, interventions chirurgicales
ou procedures suivantes : (ci-apres, une « Procedure ») suivante(s) :

Une equipe de professionnels de la sante travaillera pour realiser ma Procedure. Mon Medecin traitant/Prestataire privilegie ou un autre Prestataire privilegie designe sera present a toutes les etapes critiques de la Procedure.

- 2. Le Medecin traitant/Prestataire privilegie susdit (ou la personne qu'il aura designee - si non applicable, laisser en blanc :) m'a entierement explique, dans la langue de mon choix, ce qu'il se passera pendant et apres les soins, notamment toute Procedure supplementaire et/ou medicaments prescrits, y compris au cours de mon retablissement.
3. Je comprends qu'au cours de la Procedure proposee ci-dessus, des imprévus peuvent se produire et qu'il est possible que j'aie besoin d'une Procedure differente.
4. Je comprends que mon professionnel de la sante peut m'administrer des medicaments afin d'assurer mon bien-etre et ma securite, par exemple des anesthésiques/sédatifs/analgésiques.
5. J'accepte, le cas échéant, de recevoir des transfusions de sang ou de produits sanguins dans le cadre de ma therapie medicale.
6. J'accepte l'extraction, l'examen et la conservation d'organes, de tissus, d'implants ou d'autres fluides corporels et leur conservation a des fins scientifiques ou éducatives.
7. Dans le cadre de cette Procedure, j'autorise, le cas échéant, l'enregistrement d'images et de son a des fins éducatives, telles que présentations et publications.
8. J'autorise, le cas échéant, la présence d'observateurs autorisés dans la salle d'opération ou de thérapie.
9. J'ai indique les dispositions du présent document que je refuse.

Le patient,* Tuteur ou représentant**

Témoin de la signature

Langue choisie
Nom ou numéro de l'interprete

Signature lines for patient, witness, and interpreter with checkboxes for confirmation/refusal.

Consentement par telephone/vidéo (cochez la case, le cas échéant) : la signature du Patient/Tuteur/Représentant**/interprete n'est pas nécessaire.

The Attending Physician or Privileged Provider who is performing the procedure must sign the certification below.

I, the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have been explained to the patient/guardian/representative** and I have offered to answer any questions and have fully answered all such questions.

Signature line for attending physician with Print name, Date, and Time fields.

If more than thirty days have passed since this consent form was signed or the consent conversation was held:

I, the Attending Physician or Privileged Provider, have reaffirmed the patient/guardian/representative's** understanding and certify that there has been no substantial change to the patient's condition in the time period since the consent form was signed.

Signature line for attending physician with Print name, Date, and Time fields.

*La signature du patient doit être obtenue, à moins qu'il ait moins de 18 ans ou qu'il soit incapable.

** Aux fins du présent document, le terme « représentant » désigne un représentant légalement habilité.

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.