Mount Sinai

Mount Sinai Health System

New York

CONSENT TO SURGERY/PROCEDURE/ TREATMENT AND ANESTHESIA

Name .....

DOB .....

MRN .....

1. I hereby authorize _____ and _____ and those associates
   Attending Physician/Privileged Provider *Co-Surgeon/Privileged Provider*

   or assistants designated to perform upon _____ the following treatments, surgeries, procedures
   Name of Patient or "Me"

   (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. I understand that other medical professionals may perform some parts of the Procedure as my doctor or the Designated Privileged Provider deems appropriate.
2. The Attending Physician/Privileged Provider above (or their designee, if n/a leave blank:_____) has fully explained to me, in my preferred language what will happen during and after my care, including any additional Procedures, and/or medications I will receive, including during my recovery. They have also discussed the potential risks, benefits, and alternatives of this care. I further understand that images or sound recordings may be taken or organs, tissues, implants, or body fluids may be removed, examined, and retained for the purposes of medical care and safety improvements. If these are disposed of, it will be done according to our usual practices. I also agree to allow the presence of necessary technical or vendor support persons into the Procedure room for the purposes of my medical care. I have been informed of the likelihood of achieving the proposed goals and the reasonable alternatives to the proposed plan of care including not receiving the proposed treatments. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.
3. I understand that during the course of the above proposed Procedure something unexpected may come up and I may need a different Procedure. I consent to the additional Procedure which the above-named physician or their Associates/Assistants/Designated Privileged Providers may consider necessary.
4. I understand that my medical professional may provide me with medications to keep me comfortable and safe such as anesthetics/sedatives/analgesics. I understand that my medical professional has or will speak to me about the risks, benefits, and alternatives to these medicines before my treatment.
5. If applicable, I agree that I may need blood or blood product transfusions as part of my medical treatment. I agree that my medical professional has spoken to me about the risks, benefits, and alternatives to receiving blood and blood products.

   ☐ I decline the above regarding blood or blood product transfusions.
6. If applicable, I agree that organs, tissues, implants, or other body fluids may be removed, examined and kept for scientific or educational purposes. I understand that my identity will be kept private and these are handled, stored, and if disposed of will be done according to our usual practices.

   ☐ I decline the above regarding organs, tissue, implants, and body fluids for scientific or educational purposes.
7. If applicable, I agree to allow the recording of images and sound of this Procedure for educational purposes such as presentations and publications. I understand that my identity will be kept private.

   ☐ I decline the above regarding pictures and sound recordings for educational purposes.
8. If applicable, I agree to allow authorized observers into the operating or treatment room.
   ☐ I decline the above regarding observers.
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. I believe that the patient/guardian/representative** fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

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 Health System
New York

Mount Sinai

KONSANTMAN POU CHIRIJI/ PWOSEDI/TRETMAN AK ANESTEZI

Name .....
DOB .....
MRN .....

1. Mwen otorize: _____ ak _____ ak kolaboratè sa yo
   Doktè responsab la/pwofesyonèl swen sante privilejye *Ko-Chirijyen/Pwofesyonèl Swen Sante Privilijye*

   oswa asistan yo chwazi yo pou yo egzekite sou _____ tretman, chiriji, pwosedi sa yo
   Non Pasyan an oswa "Mwen"

   (apre "Pwosedi") pou enkli: _____

   _____

   Yon ekip pwofesyonèl medikal pral travay ansanm pou fè pwosedi/operasyon mwen an. Doktè responsab la oswa pwofesyonèl swen sante privilejye, oswa lòt pwofesyonèl swen sante yo chwazi, ap la pou tout pati ki gen risk nan Pwosedi a. Mwen konprann gen lòt pwofesyonèl medikal ki kapab egzekite kèk pati nan Pwosedi a chak fwa doktè mwen oswa Pwofesyonèl swen sante privilejye m nan jije li apwopriye.
2. Doktè responsab la oswa pwofesyonèl swen sante privilejye ki anlè a (oswa reprezantan yo, si pa genyen kite l blanch: _____ _____) te byen eksplike m, nan lang mwen pito a, kisa ki ap pase pandan ak apre swen mwen, tankou nenpòt Pwosedi m ap gen pou m fè anplis, ak/ oswa medikaman mwen ap resevwa, san wete pandan pwosesis gerizon mwen an. Yo te pale tou sou risk ki kapab rive, avantaj ak chwa ki genyen pou swen sa. Mwen konprann tou yo kapab anrejistre imaj oswa son oswa yo kapab pran, egzamine ak kenbe ògàn, tisi, enplan, oswa likid kò pou objektif swen medikal ak amelyorasyon sekirite. Si n ap elimine yo, n ap fè sa jan nou konn abitye a. Mwen dakò tou pou kite moun ki enpòtan pou èd teknik oswa pou ede pwofesyonèl yo nan sal Pwosedi a nan objektif swen medikal. Yo te enfòme m sou posibilite pou m atenn objektif yo pwopoze yo ak chwa ki chita sou rezon pou plan swen ki pwopoze yo tankou pou pa resevwa tretman yo pwopoze yo. Yo te ban mwen opòtinite pou m poze kesyon epi yo te reponn kesyon mwen yo jis mwen jwenn satisfaksyon.
3. Mwen konprann pandan pwosedi ki pwopoze anle an ap fèt kapab gen yon bagay ki pa t atann ki rive epi mwen kapab bezwen yon lòt pwosedi. Mwen bay konsantman mwen pou lòt pwosedi a Doktè oswa Kolaboratè/Asistan/Pwofesyonèl Swen Sante Privilijye yo chwazi, non sa yo anlè a, kapab konsidere nesesè.
4. Mwen konprann pwofesyonèl medikal mwen an kapab ban mwen medikaman ki pou ede m rete konfòtab ak an sekirite tankou anestezi/sedativ/analjezik. Mwen dakò pwofesyonèl medikal mwen yo te pale ak mwen sou risk, avantaj chwa mwen genyen pou medikaman sa yo avan tretman mwen an.
5. Si aplikab, mwen dakò mwen kapab bezwen pran san oswa pwodui san sa ki ka fè pati tretman medikal mwen an. Mwen dakò pwofesyonèl medikal mwen yo te pale ak mwen sou risk, avantaj chwa ki genyen pou resevwa san ak pwodui san yo.
   ☐ Mwen pa dakò pran san oswa pwodui san.
6. Si sa aplikab, mwen dakò ògàn, tisi, enplan oswa lòt likid kò kapab retire, egzamine epi nou kapab kenbe yo nan objektif syantifik oswa edikasyon. Mwen konprann y ap kenbe idantite m prive epi enfòmasyon yo ap trete, estoke epi apre sa n ap elimine yo jan nou konn abitye fè sa.
   ☐ Mwen pa dakò yo pran ògàn, tisi, enplan, likid kò nan objektif syantifik oswa edikasyon.
7. Si aplikab, mwen aksepte bay pèmisyon pou anrejistre son ak imaj Pwosedi sa a pou edikasyon tankou prezantasyon ak piblikasyon. Mwen konprann y ap kenbe idantite m prive.
   ☐ Mwen pa dakò yo pran foto ak anrejistre son nan objektif edikasyon jan yo di l anwò a.
8. Si aplikab, mwen aksepte bay pèmisyon pou obsèvatè rete nan sal operasyon oswa tretman an.
   ☐ Mwen refize obsèvatè ki dekri ki anlè yo.
9. Mwen te make pati nan dokiman mwen pa dakò yo.

Pasyan,* Responsab Legal oswa Reprezantan**	_____ *Non ak Lèt Detache*	_____ *Siyati*	_____ *Dat*	_____ *Lè*	_____ *Relasyon oswa "ou menm"*
Siyati Temwen	_____ *Non ak Lèt Detache*	_____ *Siyati*	_____ *Dat*	_____ *Lè*	☐ Li wè Pasyan an konfime siyati *(Koche kaz si sa aplikab)*
Lang PrefereNon oswa Nimewo Idantifikasyon Entèprèt la	_____ *Ekri non ak lèt yo detache ak/oswa nimewo*	_____ *Siyati (si genyen)*	_____ *Dat*	_____ *Lè*	☐ Pasyan an refize entèprèt *(Koche kaz si sa aplikab)*

☐ **Konsantman Telefòn/Videyo (Koche kaz si sa aplikab), Siyati Pasyan/Responsab Legal**/Reprezantan pa obligatwa.**

▶ **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. I believe that the patient/guardian/representative** fully understands what I have explained and answered. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

_____	_____	_____	_____
Print name	*Attending Physician/Privileged Provider Signature*	*Date*	*Time*

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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*

* Fòk ou fè pasyan an siyen sof si pasyan an poko gen 18 lane oswa gen yon lòt rezon ki fè li pa ka siyen li.

** Nan dokiman sa, tèm "reprezantan" vle di yon reprezantan ki legalman otorize.

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