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

外科手术/手术/治疗和麻醉知情同意书

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

1. 本人特此授权 _____ 和 _____ 和指定的助手
主治医生/特许服务提供者 *联合外科医生/特许服务提供者*

或助理对 _____ 执行以下治疗、外科手术、手术
患者姓名或“本人”姓名

（简称“手术”），包括：_____

_____

一支由专业人员组成的医疗团队会齐心协力地执行本人的手术。本人的主治医生/特许服务提供者，或其他指定的特许服务提供者将执行手术的所有关键操作。本人知悉，在本人的医生或指定的特许服务提供者认为适当的情况下，其他医疗专业人员可能会执行某些部分的手术操作。

2. 上述主治医生/特许服务提供者（或其指定代表，如不适用请留空：_____）已经使用本人的首选语言充分为本人说明，在本人接受护理期间和护理结束后会出现的情况，包括任何额外手术，以及/或者本人会收到的药物，包括康复药物。他们还讨论了此次护理的潜在风险、益处及替代方案。本人还知悉，医疗团队可能会拍摄图像、录制声音，或移除、检查和保留本人的身体器官、组织、植入物或体液，以改善医疗护理和提升安全性。医疗团队会按照常规做法处理这些物品。本人还同意允许必要的技术支持人员或供应商支持人员进入手术室，以协助提供医疗护理服务。本人已被告知实现所拟定目标的可能性和所拟定护理方案的合理替代方案，包括拒绝接受拟定的治疗。本人有机会向医疗团队提问，并且本人的所有问题均得到了充分的解答。
3. 本人知悉，如果在执行上述拟定的手术时发生意外，本人可能需要接受其他手术。本人同意接受上述医生或其助手、助理、指定特许服务提供者认为必要的额外手术。
4. 本人知悉，为了让本人感到舒适和保护本人的安全，医疗团队可能会向本人提供药物，例如麻醉剂/镇静剂/止痛剂。本人知悉，在接受治疗之前，医疗团队已经或将向本人说明这些药物的风险、益处和替代方案。
5. （如适用）作为治疗的一部分，本人同意，本人可能需要接受输血或使用血液制品。本人同意医疗团队已经向本人说明接受输血和使用血液制品的风险、益处和替代方案。

   ☐ 本人拒绝接受上述有关输血或使用血液制品的内容。
6. （如适用）本人同意医疗团队移除、检查和保留本人的身体器官、组织、植入物或其他体液，以用于科学研究或教学。本人知悉，本人的身份信息将被保密处理并且医疗团队会按照常规做法处理、储存和处置这些物品。

   ☐ 本人拒绝接受上述有关将本人的身体器官、组织、植入物或体液用于科学研究或教学的内容。
7. （如适用）本人同意在此次手术中拍摄图像和录制声音以用于教学，例如演讲和出版。本人知悉，本人的身份信息将被保密处理。

   ☐ 本人拒绝接受上述有关出于教学目的而进行拍摄和录音的内容。
8. （如适用）本人同意允许经过授权的观察员进入手术室或治疗室。

   ☐ 本人拒绝接受上述有关观察员的内容。
9. 本人已经勾选此文件中本人不同意的内容部分。

患者，* 监护人或代表**	_____ *正楷姓名*	_____ *签名*	_____ *日期*	_____ *时间*	_____ *关系或“患者本人”*
签名见证人	_____ *正楷姓名*	_____ *签名*	_____ *日期*	_____ *时间*	☐ 见证患者确认签名 *（如适用，请勾选方框）*
提供首选语言支持的口译员姓名或号码	_____ *正楷姓名和/或号码*	_____ *签名（如在场）*	_____ *日期*	_____ *时间*	☐ 患者拒绝使用口译员 *（如适用，请勾选方框）*

☐ **同意接听电话/视频通话（如适用，请勾选方框），无需患者/监护人/代表**/口译员签名。**

▶ **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*

* 除非患者未满 18 岁或是无行为能力者，否则必须获得患者签名。
** 此文件中，术语“代表”指的是法定代表。

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