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

Mount Sinai Health System New York

CONSENTIMIENTO PARA OPERACIÓN/ PROCEDIMIENTO/TRATAMIENTO Y ANESTESIA

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

1. Por este medio autorizo a _____ y _____ y a los asociados
   Médico de atención directa/proveedor con autorización específica *Cirujano/proveedor con autorización específica*
   o asistentes designados para hacer a _____ los siguientes tratamientos, operaciones,
   Nombre del paciente o "Yo"
   procedimientos (llamado "procedimiento") que incluirá: _____
   _____
   Un equipo de profesionales médicos que trabajarán juntos para hacer el procedimiento. Mi médico de atención directa/proveedor con autorización específica, u otro proveedor con autorización específica designado, estará presente en todas las partes críticas del procedimiento. Entiendo que otros profesionales médicos pueden hacer algunas partes del procedimiento según lo considere apropiado mi médico o el proveedor con autorización específica designado.
2. El médico de atención directa/proveedor con autorización específica mencionado arriba (o su designado, si no corresponde, dejar en blanco: _____ _____) me explicó, en mi idioma preferido, lo que sucederá durante y después de mi atención, incluyendo cualquier otro procedimiento o medicamento que recibiré, incluso durante mi recuperación. También han hablado de los riesgos potenciales, beneficios y alternativas de esta atención. Además, entiendo que pueden grabar imágenes o sonidos y que pueden quitar, examinar y conservar órganos, tejidos, implantes o fluidos corporales para fines de atención médica y mejoras de seguridad. Si estos se eliminan, se hará según nuestras prácticas habituales. También acepto que se permita la presencia de personas de apoyo técnico o proveedores necesarios en la sala de procedimientos con el propósito de mi atención médica. Me informaron sobre la probabilidad de lograr los objetivos y las alternativas razonables del plan de atención propuesto, incluyendo no recibir los tratamientos propuestos. Me dieron la oportunidad de hacer preguntas y respondieron satisfactoriamente todas mis preguntas.
3. Entiendo que durante el curso del procedimiento propuesto arriba puede surgir algo inesperado y que es posible que necesite un procedimiento diferente. Doy mi consentimiento para el otro procedimiento que el médico mencionado arriba o sus asociados/asistentes/proveedores con autorización específica designados puedan considerar necesario.
4. Entiendo que el profesional médico puede darme medicamentos para mantenerme cómodo y seguro, como anestésicos/sedantes/analgésicos. Entiendo que el profesional médico ha hablado o hablará conmigo sobre los riesgos, beneficios y alternativas de estos medicamentos antes del tratamiento.
5. Si corresponde, acepto que puedo necesitar transfusiones de sangre o productos de la sangre como parte de mi tratamiento médico. Acepto que el profesional médico me habló sobre los riesgos, beneficios y alternativas de recibir sangre y productos de la sangre.
   ☐ No acepto lo anterior relacionado con transfusiones de sangre o productos de la sangre.
6. Si corresponde, acepto que me quiten, examinen y conserven órganos, tejidos, implantes u otros fluidos corporales para fines científicos o educativos. Entiendo que mi identidad se mantendrá privada y que estos se manejarán, almacenarán y, si se eliminan, se hará de acuerdo con nuestras prácticas habituales.
   ☐ No acepto lo anterior relacionado con los órganos, tejidos, implantes y fluidos corporales para fines científicos o educativos.
7. Si corresponde, acepto que se permita la grabación de imágenes y sonidos de este procedimiento con fines educativos como presentaciones y publicaciones. Entiendo que mi identidad se mantendrá privada.
   ☐ No acepto lo anterior relacionado con la grabación de imágenes y sonidos para fines educativos.
8. Si corresponde, acepto que se permita que haya observadores autorizados en la sala de operaciones o de tratamiento.
   ☐ No acepto lo anterior relacionado con los observadores.
9. Marqué las partes del documento que no acepto.

Paciente,* Tutor o representante**	*Nombre en letra de molde*	*Firma*	*Fecha*	*Hora*	*Relación o "Yo"*
Testigo de la firma	*Nombre en letra de molde*	*Firma*	*Fecha*	*Hora*	☐ Testigo de que el paciente confirmó la firma *(marque la casilla si corresponde).*
Idioma preferido Nombre o número del intérprete	*Escriba el nombre en letra de molde o el número*	*Firma (si está presente)*	*Fecha*	*Hora*	☐ El paciente no quiso tener un intérprete *(marque la casilla si corresponde).*

☐ **Consentimiento por teléfono/video (marque la casilla si corresponde), no se necesita la firma del paciente/tutor/representante**/intérprete.**

▶ **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*

* Debe obtenerse la firma del paciente, a menos que sea menor de 18 años o esté incapacitado.

** En todo este documento, el término "representante" se refiere a un representante autorizado legalmente.

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