



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 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. I understand that other medical professionals may perform some parts of the Procedure as my doctor or the Designated Privileged Provider deems appropriate including sensitive examinations (breast, pelvic, prostate, or rectal) if indicated for my care.

- 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 do not agree.
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 do not agree.
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 do not agree.
8. If applicable for this procedure, I agree to allow a member of my care team to perform sensitive exams (breast, pelvic, prostate, or rectal) for educational or training purposes. [] I do not agree.
9. If applicable, I agree to allow authorized observers into the operating or treatment room. [] I do not agree.
10. 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.



Mount Sinai

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New York

CONSENTIMIENTO PARA OPERACIÓN/PROCEDIMIENTO/ TRATAMIENTO Y ANESTESIA

Name: _____

DOB: _____

MRN: _____

1. Por este medio autorizo a _____ y _____ y a los asociados
o asistentes designados para hacer a _____ los siguientes tratamientos, operaciones,
procedimientos (llamado "procedimiento") que incluirá: _____

Un equipo de profesionales médicos trabajará para hacer mi 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 incluyendo exámenes médicos sensibles (mama, pélvico, próstata o recto) si son necesarios para mi atención.

- 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. Dojo 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 estoy de acuerdo.
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 estoy de acuerdo.
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 estoy de acuerdo.
8. Si se aplica a este procedimiento, estoy de acuerdo en permitir que un miembro de mi equipo de atención haga los exámenes sensibles (mama, pélvico, próstata o recto) para propósitos de educación o capacitación. [] No estoy de acuerdo.
9. Si corresponde, acepto que se permita que haya observadores autorizados en la sala de operaciones o de tratamiento. [] No estoy de acuerdo.
10. 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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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.