



Mount Sinai Health System

New York

CONSENT TO SURGERY/PROCEDURE/ TREATMENT AND ANESTHESIA

Name	1
DOB	
MRN	

 I hereby authoriz 		and			_ and those associate				
	Attending Physician/Privileged	Provider Co-Sui	rgeon/Privileged Provi	ider					
or assistants des	signated to perform upon		the followin	g treatment	s, surgeries, procedure				
(votovnod to oo "F		Name of Patient or "Me"							
(referred to as F	Procedure") to include:								
Provider, will be pre	professionals will work together to per esent for all critical parts of the Proced esignated Privileged Provider deems a	lure. I understand that other medical p							
to me, in my preferi during my recovery recordings may be improvements. If the support persons in the reasonable alter	sician/Privileged Provider above (or the red language what will happen during a rather have also discussed the potentitaken or organs, tissues, implants, or bese are disposed of, it will be done act to the Procedure room for the purpose arnatives to the proposed plan of care in questions have been answered to me	and after my care, including any additional risks, benefits, and alternatives of the body fluids may be removed, examined cording to our usual practices. I also also from medical care. I have been infolicluding not receiving the proposed to	his care. I further und d, and retained for the gree to allow the pre ormed of the likelihoo	derstand that be purposes of desence of nec and of achievin	images or sound f medical care and safety essary technical or vende g the proposed goals and				
	d that during the course of the above proposed Procedure something unexpected may come up and I may need a different Procedure. I consen ional Procedure which the above-named physician or their Associates/Assistants/Designated Privileged Providers may consider necessary.								
	d that my medical professional may provide me with medications to keep me comfortable and safe such as anesthetics/sedatives/analgesics. In that my medical professional has or will speak to me about the risks, benefits, and alternatives to these medicines before my treatment.								
	e that I may need blood or blood produks, benefits, and alternatives to receivi	, , ,	treatment. I agree the	hat my medic	al professional has spoke				
☐ I decline the abo	ove regarding blood or blood product tr	ansfusions.							
	e that organs, tissues, implants, or other ny identity will be kept private and thes								
☐ I decline the abo	ove regarding organs, tissue, implants, a	and body fluids for scientific or educat	tional purposes.		·				
	e to allow the recording of images and ny identity will be kept private.	sound of this Procedure for education	nal purposes such a	s presentation	ns and publications.				
☐ I decline the abo	ove regarding pictures and sound recor	dings for educational purposes.							
	e to allow authorized observers into thove regarding observers.	e operating or treatment room.							
. I have marked the p	portions of the document I do not agre	e to.							
Patient,* Guardian									
	Print name	Signature	Date	Time	Relationship or "self"				
ignature Witness		_			Witnessed Patient				
referred Language nterpreter	Print name	Signature	Date	Time	confirming signature (check box if applicable				
ame or Number —	Print name and/or number	Signature (if present)	Date	Time	Patient refused interpreter (check box if applicable				
	eo Consent (Check box if applicable	e), Patient/Guardian/Representati	ive**/Interpreter s	ignature not	t required.				
Telephone/Vide			•		•				
Telephone/Vide	eo Consent (Check box if applicable) Physician or Privileged Provider wh		•		•				
Telephone/Vide ► The Attending F the Attending Physici explained to the patien patient/guardian/representations.		no is performing the procedure mu that the nature, purpose, benefits, risk offered to answer any questions and have explained and answered. In the event	ist sign the certific as of, and alternatives ave fully answered al at that I was not prese	eation below. Is to the propose I such question I such the propose I such question I such the propose I such question	sed Procedure have been ons. I believe that the patient signed this form, I				
Telephone/Vide ► The Attending F the Attending Physici explained to the patien eatient/guardian/representations.	Physician or Privileged Provider wh an or Privileged Provider, hereby certify t/guardian/representative** and I have sentative** fully understands what I hav	no is performing the procedure muny that the nature, purpose, benefits, risk offered to answer any questions and have explained and answered. In the event med consent process took place. I remain	ist sign the certific is of, and alternatives ave fully answered al it that I was not prese ain responsible for ha	eation below. Is to the propose I such question I such the propose I such question I such the propose I such question	sed Procedure have been ons. I believe that the patient signed this form, I d consent from the patient				
Telephone/Vide ► The Attending F the Attending Physici explained to the patien patient/guardian/represented that the for	Physician or Privileged Provider whan or Privileged Provider, hereby certify t/guardian/representative** and I have a sentative** fully understands what I have m is only documentation that the informal Print name	no is performing the procedure must that the nature, purpose, benefits, risk offered to answer any questions and have explained and answered. In the event med consent process took place. I remained the consent process took place. I remain a strength of the consent process took place.	ist sign the certific is of, and alternatives ave fully answered al it that I was not prese ain responsible for ha	eation below. Is to the propo- Il such question ent when the paving obtained	sed Procedure have been ons. I believe that the patient signed this form, I				
Telephone/Vide The Attending F the Attending Physici explained to the patien patient/guardian/repre- understand that the for If more than this the Attending Physici	Physician or Privileged Provider whan or Privileged Provider, hereby certify t/guardian/representative** and I have a sentative** fully understands what I have m is only documentation that the information that the infor	no is performing the procedure must that the nature, purpose, benefits, risk offered to answer any questions and have explained and answered. In the event med consent process took place. I remained consent process took place. I remained the patient/guardian/representative med the patient/guardian/representative.	ist sign the certifice is of, and alternatives ave fully answered all that I was not preseatin responsible for her in the interpretation of the interpreta	eation below. Is to the propo- Il such questionent when the paving obtained was held:	sed Procedure have been ons. I believe that the patient signed this form, I d consent from the patient Date Time				
Telephone/Vide The Attending F the Attending Physici explained to the patien patient/guardian/repre- understand that the for If more than this the Attending Physici	Physician or Privileged Provider whan or Privileged Provider, hereby certify t/guardian/representative** and I have a sentative** fully understands what I have m is only documentation that the informal Print name rty days have passed since this colian or Privileged Provider, have reaffirm	no is performing the procedure must that the nature, purpose, benefits, risk offered to answer any questions and have explained and answered. In the event med consent process took place. I remained consent process took place. I remained the patient/guardian/representative med the patient/guardian/representative.	ist sign the certifice is of, and alternatives ave fully answered all that I was not preseatin responsible for her in the interpretation of the interpreta	eation below. Is to the propo- Il such questionent when the paving obtained was held:	sed Procedure have been ons. I believe that the patient signed this form, I d consent from the patient Date Time				

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





Mount Sinai Health System New York

수술/시술/치료 및 마취 동의서

Name	
DOB	
MRN	

1. 본인은		및				_ 및 그 동료
	주치의/의료진		동료 외과의/의회	로 <u>진</u>		
또는 이를 위해	지명된 보조인이		에게 다음 ㅊ	료, 수술, 시	l술(이하 "시술")	을 시행하며
010111 F100	파하되는 경우 성기하니다	환자 이름 또는"Me(본인)"				
이에는 다듬글	포함하는 것을 허가합니다					
 정무 의료팀은 본		 주치의/의료진 또는 기타 지정된 의료진은 시술	하의 모든 주요 부분에 참	스		 또는 의료진0
	하는 경우 다른 의료 전문가가 시술의 일부를				1	
	로진(또는 지정인, 해당 없는 경우 공백으로 남				추가 시술 및/또는	
약물을 포암하여 노이해습니다 츠	신료 중 및 신료 우 일어날 일에 내해 몬인이 가르 보이으 이르 미 아저 개서은 모저으로 9	선호하는 언어로 온전히 설명을 전달했습니디 경상 또는 녹음을 하거나 장기, 조직, 삽입물 또	r. 또안 몬 지료의 삼새석 느 체애은 제거 건사 민	위엄, 이섬, l 보과한 스 이	내제 망안에 대해서 으을 이해하니다.(1노 이아 간으
		당당 보인은 의료 서비스를 위해 필요한 기술 및				
제안된 목표의 실		가지를 포함해 제안된 치료 계획에 대한 합리적 [.]				
	된 시술을 진행하는 과정에서 예상치 못한 상 할 수 있는 추가 시술에 동의합니다.	황으로 인해 다른 절차가 필요할 수도 있음을 (이해합니다. 본인은 위에	명시된 의사	또는 동료/보조인/	의료진이
	진이 편안하고 안전한 상태를 유지하기 위해 l점, 대체 방안에 대해 설명했으며, 설명할 것	l 마취제/진정제/진통제 등의 약물을 제공할 수 l임을 이해합니다.	: 있음을 이해합니다. 본역	인은 담당 의료	료진이 치료 전에 0	이와 같은
5. 본인은 해당하는 설명했음에 동의		수혈이 필요할 수도 있음을 이해합니다. 본인은	: 담당 의료진이 수혈과 ¹	혈액 제제 수혈	혈의 위험성, 이점,	대체 방안을
□ 본인은 수혈 5	E는 혈액 제제 수혈과 관련한 위의 내용에 동	의하지 않습니다.				
	경우 과학적 또는 교육적 목적으로 장기, 조직 는 일반적인 관행에 따라 처리될 것임을 이히	직, 삽입물 또는 기타 체액을 제거, 검사 및 보괸 개합니다.	<u></u> 할 수 있음에 동의합니다	나. 본인은 본업	인의 신원이 기밀로	유지되고
□ 본인은 과학적	l 또는 교육적 목적을 위한 장기, 조직, 삽입물	물 및 체액과 관련한 위의 내용을 동의하지 않습	니다.			
7. 본인은 해당하는	경우 발표 및 출판물 등의 교육적 목적을 위한	한 본 시술의 영상 및 소리 녹음에 동의합니다.	본인은 본인의 신원이 기	밀로 유지될	것임을 이해합니다	나.
□ 본인은 교육적	목적을 위한 사진 및 소리 녹음과 관련한 위	의 내용에 동의하지 않습니다.				
3. 본인은 해당하는	경우 허가를 받은 참관인의 수술실 또는 치료	로실 출입에 동의합니다.				
□ 본인은 참관인	과 관련한 위의 내용에 동의하지 않습니다.					
9. 본인은 본 문서어	서 동의하지 않는 내용에 표시했습니다.					
환자,* 후견인 또는 내리인**						
매니다	이름(정자체)	서명	<i>날짜</i>	시간	관계 또는 "본인	"
등인 서명					한자가 서	명하는
	 이름(정자체)	 서명	<i>날짜</i>	시간	것을 목격	함
선호 언어 통역사 기름 또는 번호					(해당 사항이	세 제크)
	 이름(정자체) 및/또는 번호	 서명(참석한 경우)	<i>날짜</i>		_	~ = +
	,,-,	시하(급역한 8구)	<i>– '</i>	시간		
			_ ,	시간		
전화/영상 동의	리(해당 사항에 체크), 환자/후견인/대리인		Ε,	시간		역사를 거부힘 <i>에 체크)</i>
	리(해당 사항에 체크), 환자/후견인/대리인				v.	
► The Attendi	리(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider	**/통역사 서명 불필요. who is performing the procedure mu	ıst sign the certifica	ation below		베 체크)
► The Attendi	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby cer	**/통역사 서명 불필요.	ust sign the certifica	ation below	osed Procedure	에 체크) have been
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby cer atient/guardian/representative** and I ha epresentative** fully understands what I I	**/통역사 서명 불필요. who is performing the procedure murtify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even	ust sign the certificance sof, and alternatives ave fully answered all that I was not prese	ation below to the proposuch questi nt when the	osed Procedure ions. I believe tha patient signed th	have been at the his form, I
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby cer atient/guardian/representative** and I ha epresentative** fully understands what I I	**/통역사 서명 불필요. who is performing the procedure mu rtify that the nature, purpose, benefits, risk ave offered to answer any questions and h	ust sign the certificance sof, and alternatives ave fully answered all that I was not prese	ation below to the proposuch questi nt when the	osed Procedure ions. I believe tha patient signed th	have been at the his form, I
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby cer atient/guardian/representative** and I ha epresentative** fully understands what I I	**/통역사 서명 불필요. who is performing the procedure murtify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even	ust sign the certifica As of, and alternatives ave fully answered all It that I was not prese ain responsible for ha	ation below to the proposuch questi nt when the	osed Procedure ions. I believe that patient signed the ed consent from	have been at the his form, I
The Attending Phyexplained to the paratient/guardian/runderstand that the	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby ceratient/guardian/representative** and I hae presentative** fully understands what I le form is only documentation that the inf	**/통역사 서명 불필요. who is performing the procedure murtify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even formed consent process took place. I rem	ust sign the certificants of, and alternatives ave fully answered all that I was not prese ain responsible for ha	ation below to the proposuch questi nt when the ving obtains	osed Procedure ions. I believe tha patient signed th	have been at the his form, I the patient.
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby ceratient/guardian/representative** and I haepresentative** fully understands what I le form is only documentation that the inf	**/통역사 서명 불필요. who is performing the procedure mustrify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even formed consent process took place. I rem	ust sign the certificance of and alternatives ave fully answered all at that I was not prese ain responsible for har a Provider Signature sent conversation we	to the proposuch questint when the ving obtained was held:	osed Procedure ions. I believe that patient signed the ed consent from Date	have been at the his form, I the patient.
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby ceratient/guardian/representative** and I has presentative** fully understands what I le form is only documentation that the inf	**/통역사 서명 불필요. who is performing the procedure murtify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even formed consent process took place. I rem	ust sign the certificance of and alternatives ave fully answered all that I was not present ain responsible for har and the provider Signature sent conversation was a signature of the conversation of the certification o	to the proposuch questint when the ving obtained was held:	osed Procedure ions. I believe that patient signed the ed consent from Date	have been at the his form, I the patient.
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby ceratient/guardian/representative** and I has presentative** fully understands what I le form is only documentation that the inf	**/통역사 서명 불필요. who is performing the procedure mustrify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even formed consent process took place. I rem Attending Physician/Privileged Reconsent form was signed or the consefirmed the patient/guardian/representation.	ust sign the certificance of and alternatives ave fully answered all that I was not present ain responsible for har and the provider Signature sent conversation was a signature of the conversation of the certification o	to the proposuch questint when the ving obtained was held:	osed Procedure ions. I believe that patient signed the ed consent from Date	have been at the his form, I the patient.
The Attending Physical Physica	임(해당 사항에 체크), 환자/후견인/대리인 ng Physician or Privileged Provider ysician or Privileged Provider, hereby ceratient/guardian/representative** and I has presentative** fully understands what I le form is only documentation that the inf	**/통역사 서명 불필요. who is performing the procedure mustrify that the nature, purpose, benefits, risk we offered to answer any questions and have explained and answered. In the even formed consent process took place. I rem Attending Physician/Privileged Reconsent form was signed or the consefirmed the patient/guardian/representation.	ust sign the certificants of, and alternatives ave fully answered all that I was not prese ain responsible for hat the provider Signature sent conversation we's** understanding and the certification of the certification	to the proposuch questint when the ving obtained was held:	osed Procedure ions. I believe that patient signed the ed consent from Date	have been at the his form, I the patient.

^{*}환자가 18세 미만이거나 신체 능력이 없는 경우를 제외하고 환자의 서명은 필수입니다.

^{**} 본 문서에서 "대리인"은 법적으로 허가를 받은 대리인을 지칭합니다.