

## **Mount Sinai Health System** New York

### CONSENT TO SURGERY/ PROCEDURE/TREATMENT AND ANESTHESIA

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 understar 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 allo 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. 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<sup>\*</sup>The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.

<sup>\*\*</sup>Throughout this document, the term "representative" refers to a legally authorized representative.



# **Mount Sinai Health System**

New York

# সার্জারি/চিকিৎসা প্রণালী/ চিকিৎসা এবং অ্যানেস্থেসিয়ার

1.	আমি এতদ্বারা		এবং			_ এবং সেই মনোনীত সহযোগ
	-111 ( 545 (1111	ভারপ্রাপ্ত চিকিৎসক/বিশেষাধিকারপ্রাপ্ত পরিষেবা প্রদানকারী	,	সহ-সার্জন/বিশেষ অ	ধিকারপ্রাপ্ত পরিষেবা প্রদানকারী	= 41/612 4641410 126417
	বা সহকারীকে এবং	আমার উপর		—— নিম্নলিখিত চি	কিৎসা, সার্জারি, চিকিৎসা প্রণালী	<u> প্রয়োগ করার জন্য অনুমোদ</u>
	প্রদান করছি ("চিকিণ	<i>রোসার শাম বা আমার</i> ৎসা প্রণালী" হিসাবে উল্লেখ করা হয়েছে) নিম্নলিখিতগুলি অ	ন্তর্ভক্ত কর	তে:		

পেশাদার চিকিৎসকদের একটি দল আমার শল্য চিকিৎসার পদ্ধতিটি সম্পাদন করতে একসাথে কাজ করবে। আমার স্বাস্থ্যসেবা প্রদানকারী চিকিৎসক বা অ্যাটেন্ডিং ফিজিসিয়ান/ বিশেষাধিকারপ্রাপ্ত স্বাস্থ্যসেবা প্রদানকারী, বা অন্যান্য মনোনীত বিশেষাধিকারপ্রাপ্ত স্বাস্থ্যসেবাপ্রদানকারী, এই পদ্ধতিটি করার সময় সেটির সমস্ত গুরুত্বপূর্ণ অংশগুলিতে সহায়তা করার জন্য উপস্থিত থাকবেন। আমি বুঝতে পারছি যে আমার ডাক্তার বা মনোনীত বিশেষাধিকারপ্রাপ্ত স্বাস্থ্যসেবা প্রদানকারীরা উপযুক্ত মনে করলে অন্যান্য পেশাদার চিকিৎসকদের আমার সংবেদনশীল পরীক্ষা নিরীক্ষা (স্তন, পেলভিক, প্রোস্টেট বা রেক্টাল) করার নির্দেশ দিলে তারা আমার এই শল্য চিকিৎসা পদ্ধতির কিছু অংশ সম্পাদন করতে পারেন।

- 2. উপরে উল্লেখিত ভারপ্রাপ্ত চিকিৎসক/বিশেষাধিকারপ্রাপ্ত পরিষেবা প্রদানকারী (অথবা তাদের মনোনীত ব্যক্তি, যদি প্রযোজ্য না হয় তাহলে খালি রেখে দিন: ) আমার চিকিৎসার সময় এবং তার পরে কী ঘটবে তা আমার পছন্দের ভাষায় আমাকে সম্পূর্ণরূপে ব্যাখ্যা করেছেন, এর মধ্যে আমার সেরে ওঠার সময় আমি যে অতিরিক্ত চিকিৎসা প্রণালী এবং/অথবা ওমুধগুলি গ্রহণ করব তা অন্তর্ভুক্ত রয়েছে। তারা এই চিকিৎসার সম্ভাব্য ঝুঁকি, উপকারিতা এবং বিকল্পগুলি নিয়েও আলোচনা করেছেন। এছাড়াও আমি আরও বুঝতে পেরেছি যে ছবি বা সাউন্ড রেকর্ডিং নেওঁয়া হতে পারে বা শরীরের কোনও অঙ্গ, টিস্যু, ইমপ্লান্ট বা শরীরের তরল পদার্থ অপসারণ করা হতে পারে, পরীক্ষা করা হতে পারে এবং চিকিৎসা পরিচর্যা এবং নিরাপন্তাকে উন্নত করার জন্য তা রেখে দেওয়া হতে পারে। যদি এগুলো নিষ্পত্তি করা হয় তবে তা আমাদের স্বাভাবিক নীতি অনুযায়ী করা হবে। আমি আমার চিকিৎসা পরিচর্যার উদ্দেশ্যে চিকিৎসা প্রণালী পরিচালনার রুমে প্রয়োজনীয় প্রযক্তিগত বা ভেন্ডর সাপোর্ট ব্যক্তিদের উপস্থিতির অনুমতি দিতেও সম্মত। আমাকে প্রস্তাবিত লক্ষ্যগুলি অর্জন করার সম্ভাবনা এবং প্রস্তাবিত চিকিৎসা গ্রহণ না করা সহ প্রস্তাবিত পরিচর্যা পরিকল্পনার যুক্তিসঙ্গত বিকল্প সম্পর্কে অবহিত করা হয়েছে। আমাকে প্রশ্ন করার সুযোগ দেওয়া হয়েছে, এবং আমার সমস্ত প্রশ্নের উত্তর আমার সন্ধর্ষ্টি হিসাবে দেওয়া হয়েছে।
- আমি বুঝতে পেরেছি যে উপরের প্রস্তাবিত চিকিৎসা প্রণালীর সময় অপ্রত্যাশিত কিছু ঘটতে পারে এবং একটি ভিন্ন চিকিৎসা প্রণালীর প্রয়োজন হতে পারে। আমি এমন অতিরিক্ত চিকিৎসা প্রণালীর প্রতি সম্মতি দিচ্ছি যা উপরোক্ত নামের চিকিৎসক বা তাদের সহযোগী/সহকারী/মনোনীত বিশেষ অধিকারপ্রাপ্ত পরিষেবা প্রদানকারীরা প্রয়োজনীয় হিসাবে বিবেচনা করতে পারেন৷
- আমি বুঝতে পেরেছি যে আমার চিকিৎসা পেশাদার আমাকে আরামে এবং নিরাপদে রাখার জন্য চেতনানাশক/সেডেটিভ/বেদনানাশকের মতো ওষুধ প্রদান করতে পারেন। আমি বুঝতে পেরেছি যে আমার চিকিৎসা পেশাদার চিকিৎসার আগে এই ওষ্বধগুলির ঝুঁকি, উপকারিতা এবং বিকল্প সম্পর্কে আমার সাথে আলোচনা করেছেন বা করবেন।
- প্রযোজ্য হলে, আমি সম্মতি দিচ্ছি যে আমার চিকিৎসার অংশ হিসেবে আমার রক্ত বা রক্ত সম্পর্কিত প্রোডাক্ট ট্রান্সফিউশনের প্রয়োজন হতে পারে। আমি সম্মতি দিচ্ছি যে আমার চিকিৎসা পেশাদার রক্ত এবং রক্ত সম্পর্কিত প্রোডাক্ট গ্রহণের ঝুঁকি,উপকারিতা এবং বিকল্প সম্পর্কে আমার সাথে কথা বলেছেন। 🗆 আমি সম্মত নই।
- 6. প্রযোজ্য হলে, আমি সম্মতি দিচ্ছি যে শরীরের কোনও অঙ্গ, টিস্যু, ইমপ্লান্ট বা শরীরের তরল পদার্থ অপসারণ, পরীক্ষা করা হতে পারে এবং চিকিৎসা পরিচর্যা এবং নিরাপন্তাকে উন্নত করার জন্য তা রেখে দেওয়া হতে পারে। আমি বুঝতে পেরেছি যে আমার পরিচয় গোপন রাখা হবে এবং এগুলি পরিচালনা, সংরক্ষণ এবং যদি নিষ্পন্তি করা হয় তবে তা আমাদের স্বাভাবিক নীতি অনুযায়ী করা হবে। 🗆 আমি সম্মত নই।
- 7. প্রযোজ্য হলে, আমি উপস্থাপনা এবং প্রকাশনার মতো শিক্ষামূলক উদ্দেশ্যে এই চিকিৎসা প্রণালীর ছবি এবং সাউন্ড রেকর্ড করার অনুমতি দিতে সম্মত। আমি বুঝতে পেরেছি যে আমার পরিচয় গোপন রাখা হবে। 🗆 আমি সম্মত নই।
- যদি এই শল্য চিকিৎসার ক্ষেত্রে প্রযোজ্য হয় তবে আমি আমার পরিচর্যা প্রদানকারী দলের একজন সদস্যকে শিক্ষাগত জ্ঞানলাভ বা প্রশিক্ষণের উদ্দেশ্যে সংবেদনশীল পরীক্ষা নিরীক্ষা (স্তন, পেলভিক, প্রোস্টেট বা রেক্টাল) করার অনুমতি দিতে সম্মত আছি। 🗆 আমি সম্মত নই।
- প্রযোজ্য হলে, আমি অপারেটিং বা চিকিৎসার রুমে অনুমোদিত পর্যবেক্ষকদের প্রবেশের অনুমতি প্রদান করতে সম্মত। 🗆 আমি সম্মত নই।

রোগী,* অভিভাবক বা প্রতিনিধি**					
	বড় হরফে নাম		তারিখ	সময়	সম্পর্ক অথবা "নিজে"
					প্রত্যক্ষকৃত রোগী স্বাক্ষর নিশ্চিত করছে
সাক্ষীর স্বাক্ষর					্রামান্ডত কর্মেছ - <u>প্রযোজ্য হলে বক্সে টিক</u>
	বড় হরফে নাম	ষাক্ষর	তারিখ	সময়	চিহ্ন দিন)
পছন্দের ভাষা দোভাষীর					্রোগী দোভাষী প্রত্যাখ্যান
নাম বা নম্বর					করেছেন
	বড় হরফে নাম এবং/অথবা নম্বর	- স্বাক্ষর (উপস্থিত থাকলে)	তারিখ	সময়	-

#### ▶ 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 ▶ 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.

\* রোগীর বয়স যদি 18 বছরের কম না হয় বা অযোগ্য না হয় তাহলে অবশ্যই রোগীর স্বাক্ষর নিতে হবে।

\*\* এই নথি জুড়ে উল্লিখিত "প্রতিনিধি" শব্দটি আইনগতভাবে অনুমোদিত প্রতিনিধিকে বোঝায়।

Time