

Mount Sinai Health System New York

CONSENT TO SURGERY/ PROCEDURE/TREATMENT AND ANESTHESIA

2. The Attending Physician/Privileged Provider above (or their designee, if n/a leave blank:	associates or assistants designated to perform upon Name of Patient or "Me" 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. My Attending Physician/Privileged Provider, or other Designated Privileged Provider deems appropriate including sensitive examinations (breast, pelvic, prostat or rectal) if indicated for my care. 2. The Attending Physician/Privileged Provider above (or their designee, if n/a leave blank: 2. The Attending Physician/Privileged Provider above (or their designee, if n/a leave blank: 3. Indicated 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 or medical care and safety improvements. If these are disposed of, it will be done according to 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. Lunderstand that during the course of the above proposed Procedure something unexpected may come up and I may need a different Procedure. I conser to the additional Procedure which the above-maned physician or their Associates/Assistants/Designated Privider Providers may consider	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, prosta or rectal) if indicated for my care. 2. The Attending Physician/Privileged Provider above (or their designee, if n/a leave blank: 2. 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 understat 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, if will be done according to our usual practices. I also agree to allot 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. Lunderstand that during the course of the above-named physician or their Associates/Assistants/Designated Privileged Providers may consider necessary. 4. Lunderstand that my medical professional may provide me with medications to keep me comfortable and safe such as anesthetics/sedatives/analgesics understand that my medical professional may revise me above the risks, benefits, and alternatives to recei	1. I hereby authorize	Attending Physician / Dvivilens	d Provider	Co Surgoon/Driviloge - D	rovidor	$_{-}$ and those
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^{*}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 Health System New York 수술/시술/치료 및 마취 동의서

1.	본인은	T+101/01=T1	및				_ 및 그 동료
	또는 이를 위해 지명된 보조인	<i>주치의/의료진</i> 이		<i>동료 외과의/의료</i> 에게 다음 치.		s(이하 "시술")을 시행하며
	이에는 다음을 포함하는 것을	허가한니다	환자 이름 또는"Me(본인)"		, ,, , ,	_	/_ 10 11
	중요한 사항에 참여할 것입니다.	본인의 담당 의사 또는 지정	본인의 담당 의사/특수 의료 서비스 제공지 성된 특수 의료 서비스 제공자가 적절하다고 술의 일부를 수행할 수 있음을 이해합니다.	1 판단하는 경우, 본인			
2.	방안에 대해서도 논의했습니다. 있음을 이해합니다. 이와 같은 <i>7</i> 담당자의 수술실 출입에 동의합	, 중 및 진료 후 일어날 일에 다 추가로 본인은 의료 및 안전 록이 폐기될 때는 일반적인 니다. 본인은 제안된 목표의	남길 것: 대해 본인이 선호하는 언어로 온전히 설명을 개선을 목적으로 영상 또는 녹음을 하거니 관행에 따라 처리될 것입니다. 또한 본인은 실행 가능성과 제안된 치료를 받지 않는 선 가 주어졌으며, 모든 질문에 만족스러운 딥	을 전달했습니다. 또한 사장기, 조직, 삽입물 5 은 의료 서비스를 위해 대행까지를 포함해 제인	본 치료의 잠 또는 체액을 저 필요한 기술	l거, 검사 및 보 또는 공급업체	d, 대체 관할 수 지원
3.	본인은 위의 제안된 시술을 진행 의료진이 필요하다고 판단할 수		상황으로 인해 다른 절차가 필요할 수도 있 다.	있음을 이해합니다. 본 역	인은 위에 명시	시된 의사 또는	동료/보조인/
4.	본인은 담당 의료진이 편안하고 이와 같은 약물의 위험성, 이점, I		해 마취제/진정제/진통제 등의 약물을 제공 벼, 설명할 것임을 이해합니다.	당할 수 있음을 이해합니	니다. 본인은 [담당 의료진이 :	치료 전에
5.	본인은 해당하는 경우 칠료의 일 대체 방안을 설명했음에 동의합 ¹		수혈이 필요할 수도 있음을 이해합니다. 년 습니다.	본인은 담당 의료진이	수혈과 혈액 🤅	제제 수혈의 위	험성, 이점,
6.		•	도직, 삽입물 또는 기타 체액을 제거, 검사 및 것임을 이해합니다.□본인은 동의하지 읺		의합니다. 본	인은 본인의 신	원이 기밀로
7.	본인은 해당하는 경우 발표 및 출 □ 본인은 동의하지 않습니다.	한물 등의 교육적 목적을 위	l한 본 시술의 영상 및 소리 녹음에 동의합	니다. 본인은 본인의 (신원이 기밀로	유지될 것임을	이해합니다.
8.	이 시술에 적용되는 경우, 본인은 □ 본인은 동의하지 않습니다.	· 교육 또는 훈련 목적으로 i	본인의 치료팀 구성원이 민감한 검사(유방,	골반, 전립선 또는 직	장)를 수행하	는 데 동의합니!	다.
9.	본인은 해당하는 경우 허가를 받	은 참관인의 수술실 또는 치	료실 출입에 동의합니다. □ 본인은 동의하	지 않습니다.			
10	. 본인은 본 문서에서 동의하지 않	는 내용에 표시했습니다.					
환기	자,* 후견인						
또는	는 대리인**	이름(정자체)	 서명	<i>날짜</i>	 시간	관계 또는 "본인	1"
증업	인 서명				_	환자가 서 건을 목격	명하는 함
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_	Print name		Attending Physician/Privileged Pr	rovider Signature		Date	
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	Print name		Attending Physician/Privileged Pr	rovider Signature		Date	Time

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

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