

## **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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| educational or training purposes.  | educational or training purposes.  | educational or training purposes.  |  | 5 5   |  | or educational purposes suc  | ch as presentati  | ons and   |
| Patient,* Guardian Print name Signature Witness Print name Signature Print name Signature Date Time Relationship or "self" Witnessed Patient confirming signature Confirming signature Representative**  Print name Signature Date Time (check box if applicate on Number) Patient refused interpreter   | Patient,* Guardian or Representative**  Print name Signature Witness Preferred Language nterpreter Name or Number Print name and/or number Signature (if present) Date Time Relationship or "self" Witnessed Patient confirming signature (check box if applicable interpreter | Patient,* Guardian or Representative**  Print name Signature  Print name Signature  Date Time Relationship or "self"  Witnessed Patient confirming signatu confirming |  |   | ber of my care team to perfo   | rm sensitive exams (breast,  | pelvic, prostate  | , or rectal) for  |
| Patient,* Guardian  Print name  Signature  Date  Time  Relationship or "self"  Witnessed Patient confirming signature  Preferred Language Interpreter  Name or Number  Patient refused interpreter   | Patient,* Guardian  Print name  Print name  Signature  Date  Time  Relationship or "self"  Witnessed Patient confirming signature Check box if applicate nterpreter Name or Number  Print name and/or number  Signature (if present)  Date  Time  Check box if applicate interpreter (check box if applicate check box if applicate interpreter (check box if applicate check box if applicate (check box if applicate check  | Print name  Print name  Signature  Date  Time  Relationship or "self"  Relationship or "self"  Witnessed Patient confirming signature  Print name  Print name  Signature  Date  Time  Check box if applicate  Print name and/or number  Signature (if present)  Date  Time  Check box if applicate  Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative**/Interpreter signature not required.   | 9. If applicable, I agre   | e to allow authorized observers into  | the operating or treatment r   | oom. 🗆 I do not agree.   |   |   |
| Print name  Signature Witness  Print name  Signature Witness  Preferred Language Interpreter  Signature  Print name  Print name  Signature  Date  Time  Witnessed Patient confirming signature  (check box if applicate on Number  Patient refused interpreter   | Print name Signature  Bignature Witness  Preferred Language Interpreter  Name or Number  Print name and/or number  Print name  Signature  Signature  Signature  Signature  Date  Time  Relationship or "self"  Witnessed Patient confirming signature  Check box if applicable interpreter  Print name and/or number  Signature (if present)  Date  Time  Check box if applicable interpreter  Check box if applicable interpreter | Print name  Signature Witness  Print name  Signature  Print name  Signature  Date  Time  Relationship or "self"  Witnessed Patient confirming signature  Check box if applicate  Print name and/or number  Signature (if present)  Date  Time  Print name and/or number  Signature (if present)  Date  Time  (check box if applicate (check box if applicate)  Print name and/or number  | 0. I have marked the   | portions of the document I do not a   | gree to.   |  |   |   |
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| ► The Attending Physician or Privileged Provider who is performing the procedure must sign the certification below.  |  |  | explained to the patient, patient/guardian/repres  | /guardian/representative** and I have o<br>entative** fully understands what I have   | offered to answer any questions<br>e explained and answered. In the  | and have fully answered all su<br>e event that I was not present   | ch questions. I be<br>when the patient  | elieve that the signed this form,   |
| , the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have beer 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  | , the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have beer 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   | 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  |  |   |  | •  |   | e Time  |
| the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have beer 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 process. I remain responsible for having obtained consent from the patient private and that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient private and the private priv | the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have beer 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 privileged Provider Signature  Print name  Attending Physician/Privileged Provider Signature  Date  Time  | 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 patient place.    Print name   Attending Physician/Privileged Provider Signature   Date   Time  | , the Attending Physicia   | an or Privileged Provider, have reaffirm  | ed the patient/guardian/represe  | entative's** understanding and   |   | e has been no   |
| , the Attending Physician or Privileged Provider, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed Procedure have beer 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   | 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 privileged Provider Signature  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:  the Attending Physician or Privileged Provider, have reaffirmed the patient/guardian/representative's** understanding and certify that there has been no   | 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 place.  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:  the Attending Physician or Privileged Provider, have reaffirmed the patient/guardian/representative's** understanding and certify that there has been no  |  | Print name  | Attending Physician/Privil   | eged Provider Signature  |   | e Time  |

<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

## СОГЛАСИЕ НА ОПЕРАЦИЮ/ ПРОЦЕДУРУ/ЛЕЧЕНИЕ И АНЕСТЕЗИЮ

|          |   |  |   |   |  |   | 2 72101/2 141/ 2   | CCUCTOUTOM  |
|----------|---|--|---|---|--|---|--|---|
| •        | Настоящим я дак   | о разрешение   | лечащий врач / уполном<br>поставщик медицински  |   | помощник хирурга / уполном<br>поставщик медицинских у  |   | _ а также их а   | ссистентам  |
|          | или назначенны  | и помощникам про   | вести   |   | указанные ниже виді  |   | , операции и/  | или другие  |
|          |   | e — Процедура), в  | имя, фамил  | ия пациента или «мне»   |  |   |  |   |
|          | процедуры (дале   | е — Процедура), в  | частности   |   |  |   |  |   |
|          | другой назначенны по усмотрению мое   | ій уполномоченный і<br>его врача или назнач  | поставщик медицинских у   | услуг будет присутств<br>о поставщика медици  | ащий врач / уполномоченный<br>овать во время всех ключевы<br>нских услуг некоторые части Г<br>ими специалистами.   | іх этапов Пр  | оцедуры. Я по  | нимаю, что  |
| ·.       | Указанный выше ло   |  |   |   | и назначенное ими лицо — есл   |   |  |   |
|          | она также рассказа<br>фотосъемка и звук<br>медицинских целях<br>установленным тре<br>службы поддержки | ти все дополнительн<br>ил (-а) мне о потенция<br>озапись, а также воз<br>и и в целях повышен<br>бованиям. Я также г<br>поставщика в целяя<br>онативах, включая о | ые процедуры и/или лекальных рисках, преимущеможно удаление, изучения безопасности. В соотв редоставляю разрешени коказания мне медицинск | арственные препарат<br>ествах и альтернатива<br>ие и сохранение орга<br>етствующих случаях<br>ие на присутствие в пр<br>ких услуг. Меня уведс | ом для меня языке, что будет и<br>и, которые я буду принимать,<br>ах этого лечения. Кроме того, з<br>анов, тканей, имплантатов и би<br>утилизация указанных матери:<br>роцедурном кабинете техниче:<br>омили о вероятности достиже!<br>можность задать любые вопримения в<br>можность задать любые вопримения и<br>можность задать любые вопримения в<br>можность задать любые вопримения в<br>можность задать любые вопримения в<br>можность задать любые вопримения в<br>можность задать любые в<br>можность задать любые в  | в т. ч. на ста<br>я понимаю, ч<br>пологически<br>алов будет в<br>ских специа<br>ния целей п | адии выздоров<br>что может осуц<br>их жидкостей в<br>выполняться со<br>плистов или пер<br>редложенного | еления. Он/<br>ществляться<br>огласно<br>рсонала<br>о лечения и о |
| 3.       | Я даю разрешение  |  | лнительной Процедуры  |   | ные обстоятельства, требующ<br>нного выше врача или его асс  |   |  | оцедуры.  |
| ١.       | частности анестети  | ки, седативные сред  | ства и анальгетики. Я пон   | нимаю, что до провед  | е препараты для обеспечения<br>ения моего лечения мой меди<br>б альтернативах этим средства  | іцинский спе  |  |   |
|          |   |  |   |   | продуктов крови. Я подтвержд<br>также об альтернативах этим  |   |  |   |
| ò.       | образовательных ц   | елях в соответствую  | щих случаях. Я понимаю  | , что будет обеспечен   | ,<br>, тканей, имплантатов и биолог<br>на моя конфиденциальность и<br>ебованиями. □ Я не даю согла   | обработка,  |  |   |
| <b>.</b> | Я даю согласие на в   | ведение фотосъемк  | и и звукозаписи Процеду   | ры в образовательны»  | ых целях в соответствующих сл  |   | стности для пр   | езентаций и   |
| 3.       | Если это применим   | о к данной процедур  |   | ей команды по уходу і   | согласие.<br>провести осмотр интимных зон  | н (груди, таз   | а, простаты илі  | и прямой  |
| ).       | Я предоставляю раз  | эрешение на присут   | ых целях. □ Я не даю согл<br>ствие уполномоченных н   |   | иционной или процедурном ка  | бинете в сос  | ответствующих  | сслучаях.   |
| 0.       |   |  | торыми я не согласен/не   | е согласна.   |  |   |  |   |
|          | циент,* опекун или  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |   |   |  |   |  |   |
|          | едставитель**   | Има и фамилиа п  | ечатными буквами  | Подпись   |  | <br>Время   | <br>Кем приходит   | CO DOUMONTY   |
| lo,      | дпись свидетеля   | имя и фамилия п  | ечатными буквами  | ПОДПИСЬ   | дога   | Бремя   | или сам пацие  |   |
| oı       | я, фамилия или<br>мер переводчика<br>предпочтительный   | Имя и фамилия п  | ечатными буквами  | Подпись   | Дата   | Время   | (отметить,<br>Пациент  | та пациентом<br>, если применимо<br>т отказался от<br>ереводчика  |
| 35       | ык  | Имя и фамилия печатны  | іми буквами и/или номер   | Подпись (если имее  | тся) Дата  | Время   |  | , если применимо  |
|          |   |  |   | деозвонка (отметит  | ь, если применимо), подпис   | ь пациента  | /опекуна/  |   |
|          | • • •   | */ переводчика не  | •   |   | una marrat ainm tha a antificati   | on holow  |  |   |
|          |   | _  | -   | • .   | re must sign the certification in the certification in the must sign the certification in the |   | sed Procedure  | have heen   |
| xp<br>at | plained to the patient<br>tient/guardian/repres   | t/guardian/represent<br>sentative** fully unde   | ative** and I have offered<br>rstands what I have explai  | to answer any questio<br>ined and answered. In  | ons and have fully answered all the event that I was not preserted. I remain responsible for have  | such questiont when the   | ons. I believe th<br>patient signed  | at the<br>this form, I  |
| _        |   | Print name   |   | Attending Physician/P   | rivileged Provider Signature   |   | Date   | Time  |
| , tł     | he Attending Physici  | an or Privileged Prov  |   | patient/guardian/repr   | e consent conversation was<br>resentative's** understanding a<br>s signed.   |   | hat there has b  | een no  |
| _        |   | Print name   |   | Attending Physician/Pa  | rivileged Provider Signature   |   | Date   | <br>Time  |

<sup>\*</sup>Пациент должен подписать этот документ. Подпись пациента не требуется, если он не достиг 18-летнего возраста или является недееспособным.

<sup>\*\*</sup> В контексте этого документа термин «представитель» означает законного представителя.