Mount Sinai

Mount Sinai Health System
New York

Name: _____

Date of Birth: _____

MRN: _____

Escort Waiver

Discharge from Hospital After an Ambulatory Procedure Without an Escort

1. It has been explained to me before my procedure that the safest option is to leave the hospital with a responsible adult escort, but I was unable to arrange for one.
2. My physicians and I have weighed the risks and benefits of postponing my procedure versus leaving without an escort and I understand that the plan is to ensure I am safe for discharge at the end of procedure, which may include staying longer for observation and going home with a transport service which may have additional costs.
3. I understand that I may feel tired, have some physical discomfort, and may experience difficulties walking on my own. I have been told that I should not drive a motor vehicle or operate heavy machinery.
4. I assume the risk and consequences of this discharge and release my physicians, health care team, and administrators, its employees, students and medical staff from any liability which may result from this discharge.

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 treatment 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*

* 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.

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Renuncia a un acompañante

Alta del hospital sin acompañante después de un procedimiento ambulatorio

1. Me explicaron antes de mi procedimiento que la opción más segura es salir del hospital con un acompañante adulto responsable, pero no pude hacer los preparativos.
2. Mis médicos y yo hemos considerado los riesgos y beneficios de posponer mi procedimiento comparados con salir sin un acompañante y entiendo que el plan es asegurarse de que esté seguro para el alta al final del procedimiento, que puede incluir quedarme más tiempo para observación e ir a casa en un servicio de transporte que puede tener otro costo más.
3. Entiendo que podré sentirme cansado, tener algún malestar físico y tener dificultades para caminar por mi cuenta. Me dijeron que no debo conducir un automóvil u operar maquinaria pesada.
4. Yo asumo el riesgo y las consecuencias de esta alta y libero a mis médicos, a mi equipo de atención médica y a los administradores, sus empleados, estudiantes y personal médico de cualquier responsabilidad que pueda resultar de esta alta.

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 treatment 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*

* 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.