

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 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 entative** fully understands what I have	offered to answer any questions e explained and answered. In the	and have fully answered all su e event that I was not present	ch questions. I be 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
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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



الموافقة على الجراحة/الإجراء/ العلاج والتذدير

وأولئك المساعدين			e	بموجب هذا	1 . أوافق ب
	فدم الخدمة المتميز	الطبيب المعالج/ما	ميز	جر اح مشارك/مقدم الخدمة المدّ	
ات والعمليات الجراحية والإجراءات التالي	العلاج		main i . to t	ماعدين المعينين لأداء علي	أو المس
			اسم المريض أو "أنا"	إلى هذا باسم "الإجراء") ليشمل:	(یشار
				فريق من الأطباء المتخصصين معًا لتنفيذ الإجراء الخاص بي. ويكو خصصين الطبيين الأخرين قد يقومون ببعض أجزاء من الإجراء حد الدر وقائل الدوقة / إذا تر الدراد والمرادة المرادة المر	أن المت
ة الطبية وتحسينات السلامة. وفي ود الخدمة في غرفة العمليات	بها لأغراض الرعاي خاص الداعمين لمز	ف أثناء فترة النعافي لدي. وقد نا نل الجسم وفحصها والاحتفاظ بـ ن الناحية الفنية أو حضور الأش	راءات إضافية و/أو أدوية سأتلقاها، بما في ذلا تُزال الأعضاء أو الأنسجة أو الغرسات أو سوا لسماح بحضور الأشخاص اللازم حضورهم م	البروستاتا أو المستقيم) إذا تم طلبها من أجل رعايتي. حلى الطبيب المعالج/مقدم الخدمة المميز المذكور أعلاه (أو من ينو، وبلغتي المفضلة، ما سيحدث أثناء وبعد رعايتي، بما في ذلك أي إج ة. وادرك أيضًا أنه قد تُلتقط صورًا أو قد تُسجَل تسجيلات صوتية أو تخلص منها، فسيتم ذلك وفقًا لممار ساتنا المعتادة. وأو افق أيضًا على ال ض الرعاية الطبية الخاصة بي. كما أنني أبلغتُ باحتمالية تحقيق الأهد يد على جميع أسئلتي بشكل كافي.	2. لقد شر- بالكامل الرعاية حالة الذ لأغراط
وه/معاونوه/مقدمو الخدمات	ور أعلاه أو مساعد	افي الذي قد يراه الطبيب المذك	إلى إجراء مختلف. وأوافق على الإجراء الإض	نه خلال الإجراء المقترح أعلاه قد يحدث شيئًا غير متوقع وقد أحتاج ون المعينون لازمًا.	
تحدث معي أو سيتحدث معي حول	صائي الطبي لدي قد	كنات. كما أنني أدرك أن الأخد	حة والأمان، مثل أدوية التخدير/المهدنات/المع	 ن الأخصىاني الطبي لدي قد يزودني بالأدوية التي تجعلني أشعر بالرا ر وفواند وبدائل هذه الأدوية قبل علاجي.	4. أدرك أر
ل المخاطر والفوائد والبدائل لتلقي	ي قد تحدث معي حو	ن على أن الأخصائي الطبي لد;	لاجي الطبي إذا كان ذلك ينطبق. كما أنني أوافؤ	على أنني قد أحتاج إلى عمليات نقل الدم أو منتجات الدم كجزء من ع منتجات الدم. □ لا أو افق.	5. أوافق ع
ي ستظل خاصة وسيتم التعامل مع	ق. وأدرك أن هويت	العلمية أو التعليمية إذا كان ينط		على أنه يجوز إزالة الأعضاء أو الأنسجة أو الغرسات أو سوائل الجد ، وتخزينها، وإذا تم التخلص منها فسيتم ذلك وفقًا لممارساتنا المعتادة.	6. أوافق ع
	خامية ۵ لأملة	رنطرة أدرك أن همرة سترة		على السماح بتسجيل الصور والصوت لهذا الإجراء للأغراض التعليه	
تعلیمیه او تدریبیه ادا کان دلک	المستقيم) لا غراص	حوص او فحص البروستانا او	ت المناطق الحساسة (قحص اللذي أو قحص ال	على السماح لأحد أعضاء فريق الرعاية المختص بي بإجراء فحوصا فيما يخص هذا الإجراء. □ لا أوافق.	
			ج إذا كان ينطبق. 🗌 لا أوافق.	على السماح للمراقبين المعتمدين بالدخول إلى غرفة العمليات أو العلا	9. أوافق :
				نمعت علامة على أجزاء الوثيقة التي لا أوافق عليها.	10. لقد وض
					٠١١*
العلاقة أو "الذات"			التي يَدر	ي سي له**	لمريض,*الو و الممثل عن
	الوقت	التاريخ	التوقيع	الاسم باحرف واصحه	
شاهد المريض يؤكد التوقيع (ضع علامة في المربع إذا كان ينطبق)	الوقت	 التاريخ	التوقيع	الاسم بأحرف واضحة	وقيع الشاهد
رفض المريض المترجم الفوري	,	<i>C.</i> 2	Ç. 3		للغة المفضلا
رفض المريض المترجم الفوري (ضع علامة في المربع إذا كان ينطبق)	الوقت	التاريخ	التوقيع (إن وجد)	قمه ' اسم <i>واأو</i> رقم هوية المترجم القوري	اللغة المفضلاً المترجم أو را
		م څه و مطاور	ن و المدين الأمري الممثل ** اتمرة و و المتر	فقة الهاتف/الفيديو (ضع علامة في المربع إذا كان ينطبق)، توأ	N 00
		بم حیر مصوب.	يع المريض الوطني الفعد المريع المرا	ها الهاف الفيديو (فقع حرف في الفريع إذا قال ينطبق)، في	مو,
the Attending Physician or Privi explained to the patient/guardiar patient/guardian/representative*	leged Provider representativ fully understa	r, hereby certify that the re** and I have offered ands what I have explai	to answer any questions and have ined and answered. In the event th	In the certification below. If, and alternatives to the proposed Procedure have fully answered all such questions. I believe that the at I was not present when the patient signed this fresponsible for having obtained consent from the	ne form, I
Print nam			Attending Physician/Privileged Prov	ildar Signatura	Timo
If more than thirty days ha	ve passed si	er, have reaffirmed the	m was signed or the consent of patient/guardian/representative's	•	Time no
Print nam	е		Attending Physician/Privileged Prov		