

### The Mount Sinai Hospital One Gustave L. Levy Place New York, New York 10029

Name	
DOB	
MRN	

	ONSENT TO SU REATMENT ANI	RGERY/PROCEDURE/ D ANESTHESIA		MRN		
1.		Physician/Provider lated to perform upon ude:	and and	Co-Surgeon/Privileged or "Me" the fo		and those associates ent(s), surgery(ies), and/or
	will be present for a	rofessionals will work together t Il critical parts of the procedure, ctor or the Attending Designee	surgery, althoug	h other medical profession	ician/Provider nals may perfo	or Designated Attending rm some aspects of the
2.	in my preferred lang has also informed m I have been informe care. I have been inf	ician above (or his/her designee luage, the nature of the propose he of the potential benefits, risks d of the likelihood of achieving to formed of the relevant risks, ben sed treatment. I have been giver	ed care, treatmer or side effects, he proposed goa efits and side ef	including potential problen als and of the reasonable a fects related to alternative	procedures and ns that might a alternatives to t s including the	rise during recuperation. the proposed plan of possible results of not
3.	necessitate a surge	uring the course of the above pr ry, treatment, procedure differer e which the above-named physi	nt from those co	ntemplated. I consent to th	e performance	of additional surgery/
4.	an authorized provid	nay require the administration of der. I understand that I will be ma es/analgesics prior to the surge	ade aware of the	risks, benefits of, and alte	rnatives to the	der the direction of administration of
5.		the transfusion of blood or bloo een made aware of the risks, ber				
6.	Any organ(s)/tissue or educational purp	(s)/implant(s)/body fluids surgio oses and such tissues, organs a	ally removed ma and/or body fluid	y be examined and retaine s may be disposed of in ac	ed by the Hosp cordance with	ital for medical, scientific customary practice.
	procedure for medic authorized observer	otographing, videotaping and/or cal, scientific or educational pur rs and/or technical or vendor su	poses, provided pport to the Ope	my identity is not revealed erating or Treatment Room	I also consent	
		and initialed any paragraphs to v	vnich i do not co	nsent.		
or	atient*, Relative _ · Guardian	Print Name	Signature	Time	Date	Relationship Patient Confirmed
	ignature Witness:    _ terpreter Name	Print Name	Signature	Time	Date	Signature Witness (Check box if Applicable)
Of	Number Telephone Conse	Print Name ent (Check box if applicable)	Signature	Time	Date	Patient Refused Interpreter (Check box if Applicable)
		sician or Privileged Procedural	list who is perfo	rming the procedure must	sion the certi	fication below
l, t pr fu ev	the Attending Physicia roposed procedure/op illy answered all such went that I was not pre	an or Privileged Proceduralist, he peration have been explained to a questions. I believe that the pation sent when the patient signed this main responsible for having obta	reby certify that the patient/relati ent/relative/guard s form, I underst	the nature, purpose, benef ve/guardian and I have offe dian fully understands what and that the form is only do	its, risks of, and red to answer I-have explains	d alternatives to the any questions and have ed and answered. In the
	the Attending Physicia	Name Air days have passed since this co an or Privileged Proceduralist, ha he patient's condition in the time	onsent form was we reaffirmed the	e patient's understanding a	nversation wa	s held:
	Print I	Noma	ttending Physician /	Privileged Proceduralist Stanstur		no Data

\* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent. NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.



## Procedural Safety Checklist

(Non-Operating Room Location) With or Without Sedation

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## STOP, LOOK, LISTEN!

(Prior to provider leaving room)

### Specimens labeled and reconciled Pre and Post procedure diagnosis and management reviewed Key concerns for recovery and procedure reviewed Proceduralist/Second Team Member Not Applicable Yes

# Document Separate Procedure Note (including EBL)

### (Prior to patient leaving the room) Name of additional team member(s) who documented 3. Attestations (if applicable):

Proceduralist is the attending physician, or other practitioner,	Date:	Signature:	Print Name:	Proceduralist:
	Proceduralist is the attending physician, or other practitioner,	Date: Time:	Signature:  Date: Time:  Proceduralist is the attending physician, or other practitioner,	Print Name:  Signature:  Date: Time:

Safety precautions (Fire, Laser, Infection)

and expiration dates checked

Implants, supplies present

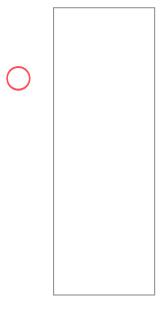
Antibiotic Plan Reviewed

Pregnancy status reviewed





(Non-Operating Room Location) With or Without Sedation



# Universal Protocol (UP) includes the pre-procedure verification, site marking (if applicable) and time out conversation.

### General Inclusions:

**General Exclusions:**The following examples are procedures that are excluded:

- insertion of an instrument or foreign material into the body. All operative and other invasive procedures that expose procedures that involve puncture or incision of the skin, patients to more than minimal risk. This includes most
- endoscopy suite, bronchoscopy suite, and interventional All procedures performed in the main operating rooms, cardiac catheterization and electrophysiology labs, radiology.
- All inpatient and ambulatory facilities (including Mount Sinai Doctors Faculty Practice) ١

- intravenous line placement, urinary catheter placement, Venipuncture, peripheral arterial line placement (radial), nasogastric tube placement, arterial blood gas
- Extremely rare occasions when procedures are performed under immediately life-threatening situations (although UP including a time out should be performed whenever possible).

Refer to Procedural Guide for Universal Protocol Applicability for further information.