Mount Sinai

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

Name _____

DOB _____

MRN _____

CONSENT TO SURGERY/PROCEDURE/ TREATMENT AND ANESTHESIA

1. I hereby authorize _____ (*Physician/Provider*) and _____ (*Co-Surgeon/Privileged Proceduralist*) and those associates or assistants designated to perform upon _____ (*Name of Patient or "Me"*) the following treatment(s), surgery(ies), and/or procedure(s) to include:

   _____

   _____

   A team of medical professionals will work together to perform my procedure/surgery. My Physician/Provider or Designated Attending will be present for all critical parts of the procedure/surgery, although other medical professionals may perform some aspects of the procedure as my doctor or the Attending Designee deems appropriate.

2. The Attending Physician above (or his/her designee: _____) has fully explained to me, in my preferred language, the nature of the proposed care, treatment, services, interventions, procedures and/or medications and has also informed me of the potential benefits, risks or side effects, including potential problems that might arise during recuperation. I have been informed of the likelihood of achieving the proposed goals and of the reasonable alternatives to the proposed plan of care. I have been informed of the relevant risks, benefits and side effects related to alternatives including the possible results of not receiving the proposed treatment. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
3. I understand that, during the course of the above proposed surgery, treatment, or procedure, unforeseen conditions may arise which necessitate a surgery, treatment, procedure different from those contemplated. I consent to the performance of additional surgery/ treatment/procedure which the above-named physician or his/her associates/assistants may consider necessary.
4. I understand that I may require the administration of anesthetics/sedatives/analgesics deemed necessary under the direction of an authorized provider. I understand that I will be made aware of the risks, benefits of, and alternatives to the administration of anesthetics/sedatives/analgesics prior to the surgery/procedure/treatment by an authorized provider.
5. I further consent to the transfusion of blood or blood components as deemed necessary for the proposed surgery/treatment/ procedure. I have been made aware of the risks, benefits of, and alternatives to the administration of these products.
6. Any organ(s)/tissue(s)/implant(s)/body fluids surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues, organs and/or body fluids may be disposed of in accordance with customary practice.
7. I consent to the photographing, videotaping and/or closed circuit televising, and publication thereof, of this surgery/treatment/ procedure for medical, scientific or educational purposes, provided my identity is not revealed. I also consent to the admission of authorized observers and/or technical or vendor support to the Operating or Treatment Room.
8. I have crossed out and initialed any paragraphs to which I do not consent.

	Print Name	Signature	Time	Date	Relationship
Patient*, Relative or Guardian					
Signature Witness:					Patient Confirmed Signature Witness ☐ *(Check box if Applicable)*
Interpreter Name or Number					Patient Refused Interpreter ☐ *(Check box if Applicable)*

☐ **Telephone Consent *(Check box if applicable)***

→ **The Attending Physician or Privileged Proceduralist who is performing the procedure must sign the certification below.**

I, the Attending Physician or Privileged Proceduralist, hereby certify that the nature, purpose, benefits, risks of, and alternatives to the proposed procedure/operation have been explained to the patient/relative/guardian and I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian 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 Proceduralist Signature	Time	Date

→ **If more than thirty days have passed since this consent form was signed or the consent conversation was held:**

I, the Attending Physician or Privileged Proceduralist, have reaffirmed the patient's understanding and certify that there has been no substantial change to the patient's condition in the time period since the consent form was signed.

Print Name	Attending Physician/Privileged Proceduralist Signature	Time	Date

* 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.

Mount Sinai

Procedural Safety Checklist

With or Without Sedation (Non-Operating Room Location)

Location: _____ Procedure: _____ Date: ____/____/____

1. Pre-procedure Verification / Time Out

(Immediately before procedure)

STOP, LOOK, LISTEN!

Proceduralist/Second Team Member		
Yes	Not Applicable	
		1. Verify with patient:
		Patient name, date of birth
		Procedure, site, laterality, Reviewed
		Site Marking Visible
		Allergies Reviewed
		2. Verify with proceduralist:
		Consent completed
		Labs reviewed
		Imaging/diagnostic reports available, with patient name, DOB, laterality
		Pregnancy status reviewed
		Antibiotic Plan Reviewed
		Implants, supplies present and expiration dates checked
		Safety precautions (Fire, Laser, Infection)

2. Debrief and Sign Out

(Prior to provider leaving room)

STOP, LOOK, LISTEN!

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

Document Separate Procedure Note (including EBL)

3. Attestations

(Prior to patient leaving the room)

Name of additional team member(s) who documented (if applicable): _____

Proceduralist:

Print Name: _____

Signature: _____

Date: _____ Time: _____

Proceduralist is the attending physician, or other practitioner, who is independently privileged to perform the procedure.

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Procedural Safety Checklist

With or Without Sedation
(Non-Operating Room Location)

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