T-CS0004

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
San Francisco General Hospital and Trauma Center

治療或醫療程序同意書
Consent for a Treatment or a Procedure (Chinese)

NAME

DOB

MRN

PCP

Patient ID / Addressograph

我的權利 (MY RIGHTS) --

關於我的健康護理計劃，我明白我有權可以作決定。我也明白我的醫生或者其他醫療提供者會給我他/她所建議的治療或者醫療程序的相關資料。相關內容會包括:

1. 醫生/醫療提供者的計劃
2. 誰將會實施治療或醫療程序
3. 它可以怎麼幫助我
4. 可能出現的意外問題
5. 其他可以實施的替代方法

什麼治療/程序 (WHAT) --

我的醫生或者醫療提供者建議我進行下列治療或者醫療程序:

醫學術語: _____

_____

一般說明: _____

_____

_____

部位（若適用）（如，功能偏側化、牙齒數、手指/腳趾）_____

在手術期間，我的狀況可能有變或者我的醫生可能會依我的狀況而需要做額外或者不同的醫療程序。我明白，我的醫生會用她/他的最佳判斷來決定如何醫治我的狀況。

對象 (WHO) --

負責治療或醫療程序的**主治(attending)醫生或所有參與的醫生**姓名:

_____.

_____

我明白，舊金山總醫院是一所教學醫院。住院醫生和其他培訓醫生可能參與治療或醫療程序中的重要部分。主治醫生會監督住院醫生和其他培訓醫生。其他持照的醫療照護者 [例如執業護士(nurse practitioners)或醫生助理(physician assistants)]也可能進行一些醫療程序或工作，但是只有在加州法律和醫院政策允許時才可以參與。

為什麼 (WHY) --

實施治療和醫療程序的理由是_____。

其他選擇 (OTHER OPTIONS) --

除了這個醫療程序之外，還可以實施:

☐ 沒有其他選擇 (Nothing) ☐ 其他 (Other): _____

以上替選方案的風險是：_____

CONSENT FOR A TREATMENT OR A PROCEDURE **治療或醫療程序同意書**

醫療結果 (OUTCOME) --

成功的機會是

☐ 極好 (Excellent) ☐ 好 (Good) ☐ 一般 (Fair) ☐ 不好 (Poor)

☐ _____

治療和醫療程序有可能會不成功，或可能造成意料之外的新問題。

風險 (RISKS) --

我的醫生或者醫療提供者，已經解釋所有治療和程序過程中會遇到的一些危險情況。她或他為我解釋了一些與建議的治療或者醫療程序相關的常見和嚴重風險。會出現如下某些(**但並非所有的**)風險: 出血；感染；對附近血管、神經、器官或者其他組織的損害；導致殘障或者死亡。

其他風險: _____

組織研究 (TISSUE STUDY) --

我明白在手術期間切除任何組織會先進行研究，以便能更瞭解我的病情而能做更好的醫治。多餘的組織會作適當的處理或為將來的研究作保留。如果組織會為將來的研究作保留:

- 我的隱私將會被保護。
- 我可能不會直接得到任何的利益，但是該項研究將來可能會帶來有助於其他病人的新發現。
- 我不會收到研究的任何款項。

我同意可以保留我的組織用於未來的研究，但是有下列條件(**如有，請列明**):

_____。

簽署之前，你還有其他問題嗎? (Before you sign, do you have any questions?)

✓ 我同意 (MY CONSENT) --

我已經得到上述資料。 我的醫生或者醫療提供者已經回答我的問題。
我希望進行所建議的治療或醫療程序。

- **病人/代理人 Patient / Representative**: 日期 (Date): _____ 時間 (Time): _____

  正楷書寫姓名 _____ 簽名 _____ 出生日期 _____

  如果你為代理人，你的關係 If a surrogate, relationship :

  ☐ 配偶/同居伴侶 Spouse/Domestic Partner, ☐ 家長 Parent, ☐ 成年子女 Adult Child

  ☐ 其他家庭成員 Other Family Member: _____,

  ☐ 醫療保健授權委託人 Power of Attorney for Health Care, ☐ 監管人 Conservator,

  ☐ 在作入院登記時，口頭委派的代理人 Surrogate orally designated by patient during this admission

- **傳譯員 Interpreter**: 日期 (Date): _____ 時間 (Time): _____

  _____ /_____/翻譯員身份證#: _____

  正楷書寫姓名 簽名 (如果親自)

- **見證人(醫療團隊成員)Witness (Member of Healthcare Team)**:

  日期 (Date): _____ 時間 (Time): _____ 簽名：_____

  正楷姓名 _____ **職位** _____

- **見證人 Witness**： **日期 (Date):** _____ **時間 (Time):** _____

正楷書寫姓名： _____ **簽名**： _____

PHYSICIAN PROGRESS NOTE FOR INFORMED CONSENT

Complete 1, 2 *OR* 3 below

1. CONSENT DISCUSSION WITH PATIENT OR SURROGATE (Complete this section together with the consent form which is signed by the patient or surrogate.)

a. As indicated on the **Consent Form** I explained the following to the patient or her/his surrogate:

--nature of the procedure or treatment,
--why it's recommended and the possible benefits,
--risks and complications (most common and serious),
--alternative treatments and the risks of each (including no treatment), and
--who will perform the procedure or treatment.

☐ At the patient's request, a friend(s) or family member(s) was present during the discussion _____.

b. ☐ An interpreter was involved. [Use a trained medical interpreter (**ext. 6-5133**) except in urgent situations or if a patient specifically requests that an adult family member serve as the interpreter.]

c. ☐ Patient has **Do Not Attempt Resuscitation (DNAR)/Do Not Intubate (DNI)** order; I explained to the patient or surrogate that the order will be suspended during the procedure.

d. ☐ Teach-Back (The patient or surrogate was able to tell me what treatment / procedure is planned, why it's needed, the benefits and some of the risks that s/he might expect.)

✔ Date:_____Time:_____Provider:_____/_____/_____/CHN ID#:_____
Print Name Signature Title

2. EMERGENCY [Complete this section when neither the patient nor a surrogate can give consent and clinically the procedure cannot be delayed to allow the hospital to petition the court for an order authorizing treatment--"*medical probate*". The consent form (*pages 1 & 2*) is not completed.]

In my clinical judgment the patient emergently needs the following treatment or procedure to alleviate severe pain or to diagnose and treat a condition that may lead to a serious disability or death; **AND** ☐ The urgency of the situation precluded getting the patient's consent in advance; **OR** ☐ I have assessed the patient and determined that s/he lacks the capacity to make health care decisions and have not been able to readily identify or locate a surrogate decision maker.

Treatment/Procedure: _____

Date:_____Time:_____Provider:_____/_____/_____/CHN ID#:_____
Print Name Signature Title

3. TELEPHONE CONSENT [Complete this section when a surrogate gives consent by telephone. The consent form (*pages 1 & 2*) is not completed.]

I assessed the patient and determined that (1) s/he lacks the capacity to make health care decisions or (2) s/he is a minor. I have located a family member or other authorized representative who is willing to act as the patient's surrogate health care decision-maker, but who cannot be physically present to sign the consent form. By telephone I discussed the nature of the treatment/procedure, expected outcome, risks and benefits and alternatives with the patient's surrogate.

- **Treatment/Procedure**:

  _____

- **Risks explained**:
  I explained that some (**but not all**) of these risks may include bleeding; infection; damage to close-by blood vessels, organs or other tissue; disability or death.

  Other risks:_____

- The surrogate has consented to the treatment/procedure on behalf of the patient.

  _____ _____ _____
  (Surrogate's Name) (Date Of Birth) (Telephone No.)

- Surrogate's relationship to patient:

  ☐ Spouse/Domestic Partner, ☐ Parent, ☐ Adult Child, ☐ Other Family Member (relationship): _____, ☐ Power of Attorney for Health Care, ☐ Conservator, ☐ Surrogate orally designated by patient during this admission

✓ Date:_____ Time: _____

Provider:_____/ _____ /_____ /_____
Print Name Signature Title CHN ID#

- Staff who was a **witness** to the telephone call:

✓ Date:_____Time:_____Name:_____/_____/_____
Print Name Signature Title