Figure: 25 TAC §601.4(a)(1)

Texas Health Center for Diagnostics and Surgery
DISCLOSURE AND CONSENT
Medical Care and Surgical Procedures

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your physician/health care provider any remaining questions you have before signing this form.

Description of Medical Care and Surgical Procedure(s)

I voluntarily request my physician/health care provider [name/credentials] _____ ,

and other health care providers, to treat my condition which is: _____

I understand that the following care/procedure(s) are planned for me:

I understand that physicians other than my operating physician, such as residents, may perform tasks related to my surgery, in accordance with the hospital's policies under the supervision of my physician.

I understand that in the course of my treatment, other qualified medical practitioners who are not physicians may perform parts of my surgery, including the administration of anesthesia. I understand that such qualified medical practitioners will perform only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital.

I understand that, at the request of my physician, a vendor or medical equipment representative not associated or affiliated with the hospital, may be present during the performance of my surgery under the supervision and control of my physician.

Potential for Additional Necessary Care/Procedure(s)

I understand that during my care/procedure(s) my physician/health care provider may discover other conditions which require additional or different care/procedure(s) than originally planned.

I authorize my physicians/health care providers to use their professional judgment to perform the additional or different care/procedure(s) they believe are needed.

Use of Blood

Please initial "Yes" or "No":

Yes_____ No I consent to the use of blood and blood products as necessary for my health during the care/procedure(s). The risks that may occur with the use of blood and blood products are:

1. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
2. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys, and immune system. Severe allergic reaction, potentially fatal.

Risks Related to this Care/Procedure(s)

Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the care/procedure(s) planned for me.

I understand that all care/procedure(s) involve some risks, ranging from minor to severe. These risks include infection, blood clots in veins, lungs or other organs, hemorrhage (severe bleeding), allergic reactions, poor wound healing, and death.

The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient's current health.

Risks of this care/procedure(s) include, but are not limited to **[include List A risks here and additional risks if any]**:

Granting of Consent for this Care/Procedure(s)

In signing below, I consent to the care/procedure(s) described above. I acknowledge the following:

- I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
- I have been given an opportunity to ask questions I may have about:
    1. Alternative forms of treatment,
    2. Risks of non-treatment,
    3. Steps that will occur during my care/procedure(s), and
    4. Risks and hazards involved in the care/procedure(s).
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

Patient/Other Legally Authorized Representative (signature required):

_____ _____

Print Name Signature

If Legally Authorized Representative, list relationship to Patient: _____

Date: _____ Time: _____ A.M./P.M.

Witness:

_____ _____

Print Name Signature

_____

Address (Street or P.O. Box)

_____

City, State, Zip Code

03/2020

PATIENT STICKER