

Texas Health Center for Diagnostics & Surgery

DISCLOSURE AND CONSENT FOR
HYSTERECTOMY
(ABDOMINAL AND VAGINAL)

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.

Notice: Refusal to consent to a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect your right to future care or treatment.

Notice: You have the right to seek consultation from a second physician before deciding whether or not to consent.

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 a hysterectomy is a removal of the uterus through an incision in the lower abdomen (abdominal hysterectomy) or vagina (vaginal hysterectomy).

I understand that the hysterectomy is permanent and not reversible. I understand that I will not be able to become pregnant or bear children.

Residents, Qualified Medical Practitioners and Vendors

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 additional surgery may be necessary to remove or repair other organs besides the uterus, including an ovary, tube, appendix, bladder, rectum, or vagina.

I understand 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.

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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.
3. 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:

Abdominal or Vaginal Hysterectomy:

1. Uncontrollable leakage of urine.
2. Injury to bladder.
3. Injury to the tube (ureter) between the kidney and the bladder.
4. Injury to the bowel and/or intestinal obstruction.
5. Need to convert to abdominal incision.

For laparoscopic, thoracoscopic, and robotic procedures, the additional risks include:

1. Damage during introduction of trocar to adjacent intra-abdominal structures and organs (e.g., bowel, bladder, blood vessels, or nerves) and potential need for additional surgery.
2. Trocar site complications (e.g., hematoma, bleeding, leakage of fluid, or hernia formation).
3. Air embolus (bubble causing heart failure or stroke).
4. Postoperative pneumothorax (collapsed lung).
5. Subcutaneous emphysema (air in between skin layers).
6. Change during the procedure to an open procedure.
7. If cancer is present, may increase the risk of the spread of cancer.

ADDITIONAL RISKS OR COMMENTS (line through if none): _____

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,

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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.

Name of Person Providing and Explaining Consent Form: _____

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

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