UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

DISCLOSURE AND CONSENT – MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Doctor(s)_____as my physician(s), and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as (lay terms)**:** Morbid Obesity-extreme overweight condition with complications and side effects

2. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures (lay terms): Weight loss surgery

Check one of the following:

☐ **Gastric bypass LAPAROSCOPIC/ROBOTIC**- surgically close a portion of the stomach and attach a portion of the small intestine to the new stomach using a camera and instruments through small incisions in the abdomen
☐ **Sleeve Gastrectomy LAPAROSCOPIC/ROBOTIC**-removal of part of the stomach using a camera and instruments through small incisions in the abdomen
☐ **Other:**

Please check appropriate box:☐ Right ☐ Left ☐ Bilateral ☐ Not Applicable

3. I (we) understand that my physician may discover other different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

4. Please initial _____**Yes**____**No**

I consent to the use of blood and blood products as deemed necessary. I (we) understand that the following risks and hazards may occur in connection with the use of blood and blood products:

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

5. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.

6. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following hazards may occur in connection with this particular procedure: Pain, severe bleeding, infection, failure of wound to heal or wound dehiscence (separation of wound), injury to organs, failure of device requiring additional surgical procedure, obstructive symptoms requiring additional surgical procedure, development of gallstones, development of metabolic and vitamin disorders. If laparoscopic surgery is utilized the following shall be in addition to risks and hazards of the same surgery when done as an open procedure: damage during introduction of trocar to adjacent intra-abdominal structures (e.g., organs, blood vessels or other vital tissues, trocar site complications (e.g. hematoma/bleeding, leakage of fluid, hernia formation), air embolus (bubble causing heart failure or stroke, postoperative pneumothorax (collapsed lung), subcutaneous emphysema (air in between skin layers), change during the procedure to an open procedure, if cancer is present may increase the risk of the spread of cancer, * Please also read complications on page 3*.

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Gastric Bypass, Sleeve Gastrectomy (cont.)

7. I (we) understand that Do Not Resuscitate (DNR), Allow Natural Death (AND) and all resuscitative restrictions are suspended during the perioperative period and until the post anesthesia recovery period is complete. All resuscitative measures will be determined by the anesthesiologist until the patient is officially discharged from the post anesthesia stage of care.

8. I (we) authorize University Medical Center to preserve for educational and/or research purposes, or for use in grafts in living persons, or to otherwise dispose of any tissue, parts or organs removed except None

9. I (we) consent to the taking of still photographs, motion pictures, videotapes, or closed-circuit television during this procedure.

10. I (we) give permission for a corporate medical representative to be present during my procedure on a consultative basis.

11. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, potential benefits, risks, or side effects, including potential problems related to recuperation and the likelihood of achieving care, treatment, and service goals. I (we) believe that I (we) have sufficient information to give this informed consent.

12. I (we) certify this form has been fully explained to me and that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

If I (we) do not consent to any of the above provisions, that provision has been corrected.

I have explained the procedure/treatment, including anticipated benefits, significant risks and alternative therapies to the patient or the patient's authorized representative.

Date	Time	Printed name of provider/agent	Signature of provider/agent
_____	_____A.M. (P.M.)	_____	_____

Date	Time
_____	_____A.M. (P.M.)

*Patient/Other legally responsible person signature _____ Relationship (if other than patient) _____

*Witness Signature _____ Printed Name _____

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415 ☐ TTUHSC 3601 4th Street, Lubbock, TX 79430
☐ UMC Health & Wellness Hospital 11011 Slide Road, Lubbock TX 79424
☐ OTHER Address: _____
Address (Street or P.O. Box) City, State, Zip Code

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No _____
Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No _____
Printed name of interpreter Date/Time

Date procedure is being performed: _____

Gastric Bypass, Sleeve Gastrectomy (cont.)

SOME ADDITIONAL POSSIBLE COMPLICATIONS DURING SURGERY

1. Injuries to abdominal organs and/or perforations (an opening or hole into the stomach or intestine).
2. Injury to the diaphragm (muscle that helps you breathe)
3. Injuries to arteries or veins which may result in excessive bleeding
4. Arrhythmia (irregular heart beat) which may result in the heart not beating or pumping properly or heart attack
5. Death

SOME POSSIBLE COMPLICATIONS AFTER SURGERY

1. Gastric outlet stenosis/obstruction which may result in blockage of the stomach
2. Small bowel obstruction which may result in blockage of the intestines/requiring additional surgery
3. Distention of the stomach
4. Acute cholecystitis (inflammation and/or infection of gallbladder)
5. Leaks involving stomach or intestine leading to peritonitis (infection of the abdomen)
6. An abscess (collection of pus) within the abdomen
7. Pneumonia (infection of the lung)
8. Phlebitis (inflammation of the veins)/DVT or PE (blood clots in the deep veins or lung arteries that may require blood thinners or additional procedures)
9. Wound dehiscence (opening up of the surgical wound)
10. Collection of blood, fluid or pus in the surgical wound
11. Bleeding from any part of the surgery
12. Breakdown of the staple line
13. Bezoar obstruction (food particles causing blockage)
14. Psychological/depression
15. Arrhythmia (irregular heartbeats/see above)/heart attack/stroke
16. Death

COMPLICATIONS WHICH MAY OCCUR SOMETIME AFTER YOUR SURGERY

1. Staple line breakdown which may result in the failure of the operation
2. Obstruction of the stomach
3. Narrowing of the anastomosis (result in inability to eat properly and/or vomiting
4. Ulcer formation in stomach or intestine anastomosis causing pain and inability to eat and can lead to perforation if untreated
5. Small bowel obstruction (blockage)
6. Hernia in the incision
7. Cholelithiasis (gallstones in the gallbladder which may require removal of the gallbladder)
8. Vomiting
9. Diarrhea
10. Dumping syndrome with the gastric bypass procedure which may result in dizziness and nausea
11. Anorexia (lack or loss of appetite)
12. Hypoglycemia (low sugar levels in blood)
13. Protein malnutrition
14. Vitamin deficiencies
15. Trace elements deficiencies
16. Partial hair loss (which is usually temporary)
17. Brittle nails
18. Skin rashes
19. Peripheral neuropathy (nerve tissue malfunction)
20. Central neuropathy (nerve tissue malfunction)
21. Psychological changes, including possible effects from new, smaller body images, affection interaction with family and friends
22. Difficulty in examining the lower part of the stomach after gastric bypass
23. Permanent alteration of dietary and bowel habits
24. Death

I HAVE READ THE ABOVE COMPLICATIONS AND UNDERSTAND THEM.

Signature of patient:_____ Date:_____

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Resident and Nurse Consent/Orders Checklist

Instructions for form completion

Note: Enter "not applicable" or "none" in spaces as appropriate. Consent may not contain blanks.

Section 1: Enter name of physician(s) responsible for procedure and patient's condition in lay terminology. Specific location of procedure must be indicated (e.g. right hand, left inguinal hernia) & **may not be abbreviated.**

Section 2: Enter name of procedure(s) to be done. Use lay terminology.

Section 3: The scope and complexity of conditions discovered in the operating room requiring additional surgical procedures should be specific to diagnosis.

Section 5: Enter risks as discussed with patient.

A. Risks for procedures on List A must be included. Other risks may be added by the Physician.
B. Procedures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be discussed with the patient. For these procedures, risks may be enumerated or the phrase: "As discussed with patient" entered.

Section 8: Enter any exceptions to disposal of tissue or state "none".

Section 9: An additional permit with patient's consent for release is required when a patient may be identified in photographs or on video.

Provider Attestation: Enter date, time, printed name and signature of provider/agent.

Patient Signature: Enter date and time patient or responsible person signed consent.

Witness Signature: Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature

Performed Date: Enter date procedure is being performed. In the event the procedure is NOT performed on the date indicated, staff must cross out, correct the date and initial.

If the patient does **not** consent to a specific provision of the consent, the consent should be rewritten to reflect the procedure that the patient (authorized person) is consenting to have performed.

For additional information on informed consent policies, refer to policy SPP PC-17.

Consent

☐ Name of the procedure (lay term)	☐ Right or left indicated when applicable
☐ No blanks left on consent	☐ No medical abbreviations

Orders

☐ Procedure Date	☐ Procedure
☐ Diagnosis	☐ Signed by Physician & Name stamped

Nurse_____Resident_____Department _____

THIS FORM IS NOT PART OF THE MEDICAL RECORD