



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): Nipple discharge from a single duct
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): Microdochectomy – surgical removal (excision) of a mammary duct
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 initialYesNo
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, temporary or permanent alteration to the shape, sensation or pigmentation of the nipple, minor change to the contour of the nipple-areola region, possible loss of breastfeeding ability, poor cosmetic results, hematoma
- 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.

. . (D.) ()

I have explained the procedure/treatment,	including	anticipated	benefits,	significant	risks	and	alternative
therapies to the patient or the patient's auth	orized repr	esentative.					

	A.M. (P	.IM.)		
Date	Time	Printed name of pro	vider/agent Signature of p	rovider/agent
	A.M. (P.M.)		
Date	Time			
*Patient/Other le	egally responsible person signature		Relationship (if other than patient	1
Tutioni other is	ogumy responsione person signature		relationship (if other than patient)	,
*Witness Signat	ure		Printed Name	
□ UMC H	02 Indiana Avenue, Lubbo Iealth & Wellness Hospita R Address:		HSC 3601 4 th Street, Lubbock bock TX 79424	TX 79430
Address (Street or P.O. Box)		City, State, Zip Code		
Interpretatio	n/ODI (On Demand Inter	oreting) 🗆 Yes 🗆 No		
•	•		Date/Time (if used)	
Alternative	forms of communication u	sed □ Yes □ No_		
			Printed name of interpreter	Date/Time
Date proced	ure is being performed:			



CONSENT FOR EXAMINATION OF PELVIC REGION

For pelvic examinations under anesthesia for student training purposes.

A "pelvic examination" means a physical examination by a health care practitioner of a patient's external and internal reproductive organs, genitalia, or rectum.

During your procedure, your health care practitioner, or a resident designated by your health care practitioner, may perform or observe a pelvic examination on you while you are anesthetized or unconscious. This is a part of the procedure to which you have consented.

With your further written consent, your health care practitioner may perform, or allow a medical student or resident to perform or observe, a pelvic examination on you while you are anesthetized or unconscious, not as part of your procedure, but for <u>educational purposes</u>.

The pelvic examination is a critical tool to aid in the diagnosis of women's health conditions. It is an important skill necessary for students to master.

Your safety and dignity is of highest importance. All students and residents are under direct supervision during pelvic examinations.

□ I consent □ I DO NOT consent to a medical student or resident being present to perform a pelvic examination for training purposes. □ I consent □ I DO NOT consent to a medical student or resident being present to observe or otherwise be present at the pelvic examination for training purposes, either in person or through secure, confidential electronic means. □ A.M. (P.M.) □ A.M. (P.M.) □ Time □ A.M. (P.M.) □ Printed name of provider/agent	You may consent of	or refuse to consent to an education	<u>nal</u> pelvic examination. Ple	ease check the box to indicate you	ur preference:
pelvic examination for training purposes, either in person or through secure, confidential electronic means. A.M. (P.M.)		O NOT consent to a medical studen	t or resident being presen	t to perform a pelvic examination	on for training
*Patient/Other legally responsible person signature A.M. (P.M.) Date Time Printed name of provider/agent *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)			0.1	•	resent at the
A.M. (P.M.) Time Printed name of provider/agent *Witness Signature Printed Name UMC 602 Indiana Avenue, Lubbock TX 79415	Date	A.M. (P.M.) Time			
Date Time Printed name of provider/agent *Witness Signature Printed Name *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 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	*Patient/Other legally responsible person signature Relationship (if other than patient)			ent)	
*Witness Signature Printed Name UMC 602 Indiana Avenue, Lubbock TX 79415		A.M. (P.M.)			
□ UMC 602 Indiana Avenue, Lubbock TX 79415 □ TTUHSC 3601 4 th 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	Time	Printed name of provide	r/agent Signature of pr	ovider/agent
□ UMC 602 Indiana Avenue, Lubbock TX 79415 □ TTUHSC 3601 4 th 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	*Witness Signature			Printed Name	
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Date/Time (if used) Alternative forms of communication used Printed name of interpreter Date/Time		Address (Street or P.O.	or P.O. Box) City, State, Zip Code		
Printed name of interpreter Date/Time	Interpretation/O	DI (On Demand Interpreting)) □ Yes □ No	Date/Time (if used)	
Data proceedure is being performed.	Alternative form	ns of communication used	□ Yes □ No	Printed name of interpreter	Date/Time
Date procedure is being performed:	Date procedure	is being performed:			



	MEDICAL CENTER ck, Texas	
Date		

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: Section 3:	Enter name of procedure(s) to be done. Use lay terminology. The scope and complexity of conditions discovered in the operating room requiring additional surgical			
Section 5:	procedures should be specific to diagnosis. Enter risks as discussed with patient.			
A. Risks fo	or procedures on List A must be included. Other risks may be added by the Physician.			
	ures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be ed with the patient. For these procedures, risks may be enumerated or the phrase: "As discussed with patient".			
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.			
	s not consent to a specific provision of the consent, the consent should be rewritten to reflect the procedure that orized person) is consenting to have performed.			
	For additional information on informed consent policies, refer to policy SPP PC-17.			
Consent				
☐ Name of th	ne procedure (lay term) Right or left indicated when applicable			
☐ No blanks	left on consent			
Orders				
Procedure 1	Date Procedure			
☐ Diagnosis	☐ Signed by Physician & Name stamped			
NT	Desident Descriptions			