UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

DISCLOSURE AND CONSENT – TRANSESOPHAGEAL ECHOCARDIOGRAM 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):** Possible blood clot or abnormality of heart

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): Transesophageal Echocardiography – (ultrasound exam of the heart from inside the throat) to bounce sound waves off the heart and image heart

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, sore throat, vocal cord damage, esophageal perforation (hole or tear in tube from mouth to stomach).

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.

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Transesophageal Echocardiography (TEE) cont.

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.

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

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

_____
*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: _____

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Lubbock, Texas

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DISCLOSURE AND CONSENT
ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA)

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended anesthetic/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia 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 anesthesia/analgesia.

ADMINISTRATION OF ANESTHESIA/ANALGESIA

The plan is for the anesthesia/analgesia to be administered by (Note that the provider listed may change depending on the length of the procedure or other circumstances). I acknowledge that other anesthesia care team members in an anesthesiology residency, medical, Certified Registered Nurse Anesthetist (CRNA), and/or paramedical training program may participate in the care provided to me under the medical oversight of an attending physician at UMC. Non-CRNA nurse sedation is governed by a qualified medical provider. Perioperative means the period shortly before, during and shortly after the procedure.

CHECK THE PLANNED APPROACH AND HAVE THE PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE INITIAL:

(Check one)

☐ _____Physician Anesthesiologist Dr._____/Faculty, Texas Tech Physicians, Dept of Anesthesiology [NAME]
☐ _____Dentist Anesthesiologist Dr._____[NAME]
☐ _____Non-Anesthesiologist Physician or Dentist Dr. _____[NAME]

(Check all that apply if the administration of anesthesia/analgesia is being delegated/supervised/medically directed by the above provider)

☐ _____Certified Anesthesiologist Assistant: _____Provider, TTUHSC, Department of Anesthesiology [NAME]
☐ _____Certified Registered Nurse Anesthetist: _____Provider, TTUHSC, Department of Anesthesiology [NAME]
☐ _____Physician in Training: _____TTUHSC, Department of Anesthesiology [NAME]

The above provider(s) can explain the different roles of the providers and their levels of involvement in administering the anesthesia/analgesia.

Types of Anesthesia/Analgesia Planned and Related Topics

I understand that anesthesia/analgesia involves additional risks and hazards. The chances of these occurring may be different for each patient based on the procedures(s) and the patient's current health. I realize the type of anesthesia/analgesia may have to be changed possibly without explanation to me.

I (we) understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest (heart stops beating), brain damage, paralysis (inability to move), or death.

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.

I (we) also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

☐ _____ **GENERAL ANESTHESIA** : injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction /memory loss; permanent organ damage; brain damage.

☐ ___ **REGIONAL BLOCK ANESTHESIA / ANALGESIA**: nerve damage; persistent pain; bleeding/ hematoma; infection; medical necessity to convert to general anesthesia; brain damage.
LOCATION:_____

☐ ___ **SPINAL ANESTHESIA / ANALGESIA:** nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ ___ **EPIDURAL ANESTHESIA / ANALGESIA**: nerve damage; persistent back pain; headache; infection; bleeding /epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.

☐ _____ **MONITORED ANESTHESIA CARE (MAC) or SEDATION / ANALGESIA**: memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐ _____ **DEEP SEDATION:** memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

☐ _____ **MODERATE SEDATION:** memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.

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ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT (ANALGESIA) (cont.)

Additional comments/risks:

_____

_____

I (we) understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I (we) have been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I believe that I have sufficient information to give this informed consent.

Anesthesia Risks for Young Children and During the Third Trimester of Pregnancy

I (we) have been informed of the potential adverse effect of anesthesia in young children especially for procedures that may last longer than 3 hours or if multiple procedures are required. I have been informed that the use of general anesthetic and sedation drugs in children younger than 3 years or in pregnant women during their third trimester may affect the development of children's brains.

I have received the FDA Drug Safety Communication bulletin detailing the risks of general anesthesia on brain development in children under the age of 3 years or in third trimester pregnant women.

( ) Yes ( ) Not Applicable

Pregnancy Risks (for women of childbearing age)

It is recommended that elective surgery be delayed until after pregnancy. No one knows the exact risk of birth defects or the possibility of spontaneous abortion from anesthesia. No anesthesia drug or technique can be assured to be safe.

I have read the risks of anesthesia in pregnancy and have been offered a pregnancy test.

Pregnant ( ) Yes ( ) No ( ) Do not know ( ) Not applicable

This form has been fully explained to me, I have read it or have had it read to me, the blank spaces have been filled in, and I understand its contents.

***DATE**_____ **TIME:**_____ **A.M. or P.M.**

_____
*PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN 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
☐ GI & Outpatient Services Center 10206 Quaker Ave, Lubbock TX 79424
☐ OTHER Address:_____
Address (Street or P.O. Box) City, State, Zip Cod

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: _____

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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 educational purposes.

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.

You may consent or refuse to consent to an educational pelvic examination. Please check the box to indicate your preference:

☐ 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.)**
Date **Time**

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

_____ _____ **A.M. (P.M.)** _____ _____
Date **Time** **Printed name of provider/agent** **Signature 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) ☐ Yes ☐ No _____
Date/Time (if used)

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

Date procedure is being performed: _____

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UNIVERSITY MEDICAL CENTER
Lubbock, Texas

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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: 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