UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

DISCLOSURE AND CONSENT – COMMUNITY CARE DIABETIC SURVEILLANCE

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended surveillance procedure(s) to be used so that you may make the decision whether or not to undergo surveillance testing. 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 University Medical Center and such associates, technical assistants and other health care providers as they may deem necessary to evaluate my condition which has been explained to me (us) as (lay terms)**: Possible diabetes**
2. I (we) understand that the following surveillance procedures are planned for me and I (we) voluntarily consent and authorize these procedures (lay terms)**: A. Diabetic foot exam B. Point of care testing: finger stick to check blood sugar level**

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

3. I (we) understand that other conditions which require additional or different procedures than those planned may be discovered.
4. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.
5. I (we) consent to the taking of still photographs during this procedure.
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 medical and/or diagnostic procedures planned for me. I (we) realize that the following hazards may occur in connection with this particular procedure: Pain, bruising, slight bleeding, infection
   ____
7. I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment and the procedures to be used I (we) believe that I (we) have sufficient information to give this informed consent.
8. 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

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

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

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*Witness Signature — Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415

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: ______________________________

1205