UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

UMC Informed Consent
Feeding Banked Donor Human Breast Milk

I have been advised by UMC that my baby may receive banked donor human breast milk as part of his/her treatment during his/her hospitalization.

I am aware that donor milk used at UMC comes from Mothers' Milk Bank of North Texas. Mother's Milk Bank of North Texas has represented to UMC that its donor milk meets Human Milk Banking Association of North America's requirements for testing and safety including but not limited to testing and screening for infectious diseases such as HIV-I/II (AIDS), hepatitis B & C, HTLV-I/II and syphilis and that the donor milk has been pasteurized to kill bacteria or viruses.

UMC DOES NOT INDEPENDENTLY TEST THIS DONOR MILK AND DISCLAIMS ANY AND ALL WARRANTIES OR GUARANTEES RELATED TO THE DONOR MILK, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE. UMC SHALL HAVE ABSOLUTELY NO LIABILITY IN CONNECTION WITH THE DONOR MILK OR FOR ANY LOSS OR INJURY CAUSED, IN WHOLE OR IN PART, BY ITS ACTIONS, OMISSIONS, OR NEGLIGENCE, OR FOR ANY DECISION MADE OR ACTION TAKEN OR NOT TAKEN IN RELIANCE UPON THE INFORMATION FURNISHED.

I acknowledge that despite careful donor screening, testing and pasteurization for the above infectious diseases, there is still a risk of transmission of disease to my baby.

I understand that along with my physician and his or her assistants, other authorized medical center personnel may be involved in the administration of donor milk to my baby.

I understand once I have signed this informed consent no further informed consent for the administration of human donor milk to my baby will be required during this hospitalization. I understand that I should ask more questions whenever I need additional information.

I also acknowledge that I am satisfied with the explanation I have been given about the benefits and risks associated with donor breast milk. I fully understand what I am signing of my own free will.

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

☐ 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

1205

UMC HEALTH SYSTEM
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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