UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

Whole Body Cooling Treatment with Parental Consent

I have been explained by __________________________ that my child had low Apgar scores, significant metabolic acidosis with clinical findings consistent with possible Hypoxic Ischemic Encephalopathy after delivery.

This increases the risk of brain injury, neurological delay and possible death in my child.

Also, whole body hypothermia has been explained to me as a treatment that may help to diminish the brain damage in my child, consisting of:

- ☐ Decreasing total body temperature to 33.5 Celsius degrees (92.3 Fahrenheit degrees) with a cool blanket for 72 hours
- ☐ Connecting the child to an EEG monitor looking for seizure activity
- ☐ Using Phenobarbital to control seizures if needed
- ☐ Following my child at the High Risk Clinic for neurological development

I have been explained the possible risk of the whole body hypothermia as well as the complications of not allowing the child to be treated. Possible complications are as follows:

- ☐ Sinus bradycardias
- ☐ Hypotension requiring Rx
- ☐ Arrhythmias requiring Rx
- ☐ Coagulation disorders
- Electrolyte disturbances
- Olyguria
- Sepsis
- Seizures

I understand that this therapy has been reported beneficial treating the condition my child is in, but there is no guarantee this will be successful all the time.

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 79415

☐ 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: __________________________

1205

UNIVERSITY MEDICAL CENTER
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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