

**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**): Head Trauma

2. **SURGICAL PROCEDURE:** 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):** Craniectomy is a neurosurgical procedure where part of the skull is removed to allow a swelling brain room to expand without being squeezed.

3. **INTRAOPERATIVE NEUROPHYSIOLOGICAL MONITORING:** I (we) understand that intraoperative neurophysiological monitoring (IOM) may be utilized to identify neural structures, aid in performing the surgical procedure, and detect and prevent injury to the nervous system.

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

4. 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.

5. I (we) (do) (do not) 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.

6. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.

7. 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, loss of brain function such as memory and/or ability to speak, recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse), stroke (damage to brain resulting in loss of one or more functions), loss of senses (blindness, double vision, deafness, smell, numbness, taste), weakness, paralysis, loss of coordination, cerebrospinal fluid leak with potential for severe headaches, meningitis (infection of coverings of brain and spinal cord), brain abscess, persistent vegetative state (not able to communicate or interact with others), hydrocephalus (abnormal fluid buildup causing pressure in the brain), seizures (uncontrolled nerve activity), need for permanent breathing tube and/or permanent feeding tube





## 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 4<sup>th</sup> 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: \_\_\_\_\_





UNIVERSITY MEDICAL CENTER  
Lubbock, Texas

Patient Label Here

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

<input type="checkbox"/> Name of the procedure (lay term)	<input type="checkbox"/> Right or left indicated when applicable
<input type="checkbox"/> No blanks left on consent	<input type="checkbox"/> No medical abbreviations

### Orders

<input type="checkbox"/> Procedure Date	<input type="checkbox"/> Procedure
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Signed by Physician & Name stamped

Nurse \_\_\_\_\_ Resident \_\_\_\_\_ Department \_\_\_\_\_

THIS FORM IS NOT PART OF THE MEDICAL RECORD