



DISCLOSURE AND CONSENT MEDICAL AND SURCICAL PROCEDURES

<b>TO THE PATIENT:</b> 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 <b>condition</b> which has been explained to me (us) as ( <b>lay terms</b> ):							
2. I (we) understand that the following surgical, medical, and/or diagnostic <b>procedures</b> are planned for me and I (we) voluntarily consent and authorize these <b>procedures</b> ( <b>lay terms</b> ): <u>Hysterosalpingogram (HSG) - Uterine Dye Injection-Injection of dye into uterus to visualize the uterine cavity, cervix, fallopian tubes to rule out strictures, tears, and to check patency</u>							
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 initialYesNo							
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.
- Severe allergic reaction, potentially fatal. c.
- 5. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.
- 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, need for further procedures
- 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.
- 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





## Hysterosalpingogram (HSG) (cont.)

- 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.

I have explained the procedure/treatment, including anticipated benefits, significant risks and alternative

IF I (WE) DO NOT CONSENT TO ANY OF THE ABOVE PROVISIONS, THAT PROVISION HAS BEEN CORRECTED.

therapies to the	e patient or the patient's author	orized representative			
	A.M. (P.M.)				
Date	Time	Printed name of provide	er/agent	Signature of provi	der/agent
	A.M. (P.M.)				
Date	Time				
*Patient/Other legal	lly responsible person signature		Relationsh	ip (if other than patient)	
*Witness Signature			Printed Na	me	
	Indiana Avenue, Lubbock Talth & Wellness Hospital 110			*	X 79430
	O. Box)	City, State, Zip Code			
Interpretation/	ODI (On Demand Interpreting	g) 🗆 Yes 🗆 No			
			Date/Tim	e (if used)	
Alternative for	rms of communication used	☐ Yes ☐ No	Printed n	ame of interpreter	Date/Time
Date procedure	e is being performed:			and of merpreter	Duto/ Time



## **Resident and Nurse Consent/Orders Checklist**

## **Instructions for form completion**

			-				
Note: Enter "no	ot applicable" or "none" in	spaces as appropriate. C	onsent 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:				viacu.			
Section 3:	Enter name of procedure(s) to be done. Use lay terminology.  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 w	th patient.					
			may be added by the Physician.				
			Disclosure panel do not require that sp				
			ted or the phrase: "As discussed with	n 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.						
	es <b>not</b> consent to a specific prorized person) is consenting		consent should be rewritten to reflec	t the procedure that			
Consent	For additional information	on informed consent polic	ies, refer to policy SPP PC-17.				
☐ Name of t	he procedure (lay term)	Right or left indicat	ed when applicable				
☐ No blanks left on consent		☐ No medical abbrevi	ations				
Orders				_			
☐ Procedure Date		Procedure					
☐ Diagnosis	3	☐ Signed by Physicia	n & Name stamped				
Nurse	Resi	dent	Department				