CANCER CENTER
UMC HEALTH SYSTEM

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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)**:** Prostate cancer, elevated PSA (Prostate Specific Antigen)

2. 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)**:** Injection of SpaceOAR hydrogel (gel-like material) into the space between the prostate and rectum to temporarily position the rectal wall away from the prostate during radiotherapy for prostate cancer; Placement of Gold Seed markers and/or prostate biopsy (remove piece of prostate tissue to examine under microscope).

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 initial _____**Yes**_____**No**

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.
c. Severe allergic reaction, potentially fatal.

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

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 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, pain associated with SpaceOAR hydrogel injection, pain or discomfort associated with SpaceOAR hydrogel, pain associated with injection of local anesthesia, needle penetration of the bladder, prostate, rectal wall, rectum or urethra, injection of SpaceOAR hydrogel into the bladder, prostate, rectal wall, rectum or urethra, local inflammatory reactions, injection of air, fluid or SpaceOAR hydrogel intravascularly, urinary retention, rectal mucosal damage, ulcers, necrosis, constipation and rectal urgency, hematuria, urinary retention, urinary tract infection and/or blood stream infection, pain or discomfort in the penis.

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.

Radiation Therapy (cont.)

ALL FEMALES MUST COMPLETE: I (we) understand that radiation can be harmful to the unborn child.

( ) I am pregnant ( ) I could be pregnant ( ) I am not pregnant

_____**INITIAL IF APPLICABLE:**

I HAVE AN IMPLANTED ELECTRONIC DEVICE (such as a pacemaker, defibrillator or nerve stimulator). I understand radiation to the device can cause malfunction of the device.

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

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.

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.

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

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No _____
Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No _____
Printed name of interpreter Date/Time

****CONSENT VALID FOR ONE YEAR FROM DATE OF SIGNATURE****

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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 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: _____

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SpaceOAR & Fiducial Gold Seed Placement

About the procedure & what to expect:	Preparation for Procedure:
SpaceOAR hydrogel is an absorbable gel that creates space between the prostate and the rectum and is used to protect the rectum from radiation exposure. The gel stays in place for about three months and is naturally absorbed and excreted in the urine after six months. **Gold fiducial markers are inserted into the prostate by a process similar to a biopsy. Fiducials are placed to guide radiation treatment which helps to avoid injury to the surrounding structures like the rectum and bladder.** • Procedure will require a signed consent • Inform your provider of any medication allergies • A broad spectrum antibiotic, topical anesthetic, anti-anxiety, and pain medication will be prescribed • Stop all blood thinners 5-7 days prior to procedure • PT/PTT/INR lab draw day prior to procedure if on thinners • A local anesthetic will be used for the procedure • You will be expected to lie flat in a lithotomy position for 1 to 1 ½ hours and it is very important to lie very still with no movement below the waist • CT scan and MRI will be completed the same day of your procedure **Side Effects May Include:** • Bleeding • Infection • Pain • Blood in the urine, stool, and semen	**Pre Procedure Instructions:** • The day prior to your procedure begin a clear liquid diet • Fleets Enema day prior to procedure and 2-3 hours prior to procedure • Prescribed medication (antibiotic, anti-anxiety, pain) should be taken one hour prior to procedure start • Apply Emla cream generously to the saddle area **Post Procedure:** • Ensure someone is available to drive you home • Rest • Normal activity can be resumed by same day if no complications post procedure • Post procedure instructions will be given by your nurse which will include post procedure care • Inform your provider of any post procedure complications • Radiation treatment will begin approximately one week after SpaceOAR and gold seed placement • NOTE: A full bladder and empty bowel is preferred for your daily radiation treatment. Your nurse will provide specific instruction prior to radiation start.

Caring for yourself during radiation treatment

Follow your provider's orders. If you are unsure of the treatment you are receiving, ask your provider or radiation team. Side effects are not the same for all patients. **Note: radiation side effects are limited only to the area being treated**. Notify your provider if you experience new symptoms.

For questions or concerns related to radiation treatment, contact your provider or nurse at (806) 775-8568. After 5:00 pm, on weekends and holidays, please call 806 775-8600. In the event of an emergency, call 911 or go to the nearest emergency center.

Our goal is to provide you with very good care.
Thank you for choosing UMC Cancer Center Radiation Oncology

Service is our passion!

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