



DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

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): Fractured vertebrae
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): Kyphoplasty (Balloon expansion and cement injected into fractures)/Vertebroplasty (cement injected into fractures of spine) with possible bone biopsy
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.
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, nerve/spinal cord injury, need for emergency surgery, embolization of cement (cement used passes into blood
vessels and possibly going all the way to the lungs), collapse of adjacent vertebrae (bones in spine), leak of
cerebrospinal fluid (fluid around the spinal cord), pneumothorax (collapsed lung), failure to relieve pain, rib

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

TO THE PATIENT: You have the right as a patient to be informed about your condition and the

discharged from the post anesthesia stage of care.





Kyphoplasty/Vertebroplasty (cont.)

8. I (we) authorize University Medical Center to preserve for educe in grafts in living persons, or to otherwise dispose of any tissu	
9. I (we) consent to the taking of still photographs, motion pict during this procedure.	ures, videotapes, or closed circuit television
10. I (we) give permission for a corporate medical representation consultative basis.	ive to be present during my procedure on a
11. I (we) have been given an opportunity to ask questions about and treatment, risks of non-treatment, the procedures to be used, a benefits, risks, or side effects, including potential problems reachieving care, treatment, and service goals. I (we) believe that I informed consent.	and the risks and hazards involved, potential lated to recuperation and the likelihood of
12. I (we) certify this form has been fully explained to me and the me, that the blank spaces have been filled in, and that I (we) under	
IF I (WE) DO NOT CONSENT TO ANY OF THE ABOVE PROVISIONS, T	HAT PROVISION HAS BEEN CORRECTED.
I have explained the procedure/treatment, including anticipated therapies to the patient or the patient's authorized representative.	l benefits, significant risks and alternative
Date Time A.M. (P.M.) Printed name of provider	Signature of provider/agent
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 ☐ TTUHS☐ UMC Health & Wellness Hospital 11011 Slide Road, Lubboc☐ 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:	<u> </u>



Date	

Resident and Nurse Consent/Orders Checklist

Instructions for form completion

			-				
Note: Enter "no	ot applicable" or "none" in	spaces as appropri	ate. 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:		, ,		ex may not be abbit	cviacea.		
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 procedure should be specific to diagnosis.						
Section 5:	Enter risks as discussed wi						
A. Risks f	or procedures on List A mus	st be included. Other	risks may be added by	the Physician.			
	ures on List B or not address e patient. For these procedu						
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 not consent to a specific porized person) is consenting		ent, the consent should	l be rewritten to refle	ect the procedure that		
Consent	For additional information	on informed consen	t policies, refer to polic	cy SPP PC-17.			
☐ Name of th	ne procedure (lay term)	Right or left in	ndicated when applicat	ole			
☐ No blanks	left on consent	☐ No medical ab	breviations				
Orders							
Procedure	Date	Procedure					
☐ Diagnosis		☐ Signed by Ph	ysician & Name stamp	ed			
Nurse	Res	ident	De	enartment			