

**Patient Label Here** 

## 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**): \_\_\_\_\_\_ Vascular tumor of the neck\_

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**): <u>Carotid Body Tumor Removal</u>-Placement of skin incision in the neck with removal of mass next to the carotid artery

# 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: <u>Pain, hemorrhage (bleeding), infection, paraplegia (inability to move), kidney damage, stroke, acute myocardial infarction (heart attack), infection of graft, injury to or occlusion (blocking) of artery, damage to other parts of the body supplied by the artery with resulting loss of use or amputation (removal of body part), worsening of the condition for which the procedure is being done, stroke and/or seizure (for procedures involving blood vessels supplying the spine, arms, neck, or head), contrast-related temporary blindness or memory loss (for studies of the blood vessels of the brain), paralysis (inability to move) and inflammation of nerves (for procedures involving blood vessels of the spine), contrast neuropathy (kidney damage due to contrast agent used during procedure, thrombosis (blood clot forming at or blocking the blood vessel) at access site or elsewhere</u>

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## Carotid Body Tumor Removal (cont.)

**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: <u>NONE</u>

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.

	A.M. (	P.M.)					
Date	Time	Prin	ted name of provide	er/agent	Signature of provid	ler/agent	
	A.M. (	P.M.)					
Date	Time						
*Patient/Other legally responsible person signature			Relationship (if other than patient)				
*Witness Signature			Printed Name				
GI & Out	2 Indiana Avenue, Lubb tpatient Services Center ealth & Wellness Hospit ldress:	10206 Quaker	Ave, Lubbock	x TX 79424	eet, Lubbock, T	X 79430	
Address (Street or P.O. Bo				City, State, Zip Code			
Interpretatio	on/ODI (On Demand Int	erpreting)	Yes □ No				
Alternative	forms of communicatio	n used 🛛	Yes 🛛 No	Date/Time (if	used)		
				Printed name	of interpreter	Date/Time	
Date proced	lure is being performed:						
Rev 02/01/2024						1205	



## **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) & <b>may not be abbreviated.</b>	
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	
a	procedures should be specific to diagnosis.	
Section 5:	Enter risks as discussed with patient.	
	or procedures on List A must be included. Other risks may be added by the Physician.	
	ures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be discussed	
Section 8:	e patient. For these procedures, risks may be enumerated or the phrase: "As discussed with patient" entered. 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	
beetion 9.	photographs or on video.	
Provider	Enter date, time, printed name and signature of provider/agent.	
Attestation:		
Patient	Enter date and time patient or responsible person signed consent.	
Signature:		
Witness	Enter signature, printed name and address of compotent edult who witnessed the patient or outhorized person's	
Signature:	Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature	
Signature.	Signature	
Performed	Enter date procedure is being performed. In the event the procedure is NOT performed on the date	
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			
Oudous				
Orders				
Procedure Date	Procedure			
Diagnosis	Signed by Physician & Name stamped			

 Nurse\_\_\_\_\_Resident\_\_\_\_\_Department \_\_\_\_\_

THIS FORM IS NOT PART OF THE MEDICAL RECORD