MEDICAL, SURGICAL AND DIAGNOSTIC PROCEDURES

I have explained the procedure, risks, hazards, benefits, likelihood of achieving goals, alternatives, and risks to alternative therapy to the patient/other legally responsible person.

Physician Signature: ______________________ Provider ID#: ____________ Date: ____________ Time: ________

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.

- I (We) voluntarily request Dr. ______________________ as my physician, and such associates, technical assistants, residents, and other health care providers as he or she may deem necessary, to treat my condition which has been explained to me as:

- I (We) understand that the following surgical, medical and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures:

- I (We) understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I 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.
- If an implant is used, I consent to the release of related information, including my social security number, to the manufacturer of the implantable device as required by law.
- I (We) have been given an opportunity to ask my physician(s) questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I have sufficient information from my physician(s) to give this informed consent.
- 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 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 also realize that the following risks and hazards may occur in connection with this particular procedure:

- I _initials_ **consent** _initials_ **do not consent** to the use of blood or blood products as deemed necessary during my surgical, medical and/or diagnostic procedure and if necessary, after my surgical, medical and/or diagnostic procedure is completed, but while I am still in the hospital: I (We) understand the risks hazards associated with the use of blood and blood products are: fever, allergic reactions, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections. The benefits, risks and alternatives have been explained to me.

- I _initials_ **consent** _initials_ **do not consent** the photographing or videotaping of the procedure(s) or operation(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, providing that my identity is not revealed by descriptive texts accompanying the pictures.

Patient Name:

Date of Birth:

PATIENT LABEL

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

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DISCLOSURE AND CONSENT