

**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 as he/she may deem necessary (for example anesthesia providers, educational assistants, and other health care providers who are identified and their professional role explained to me) to treat my condition. My condition has been explained to me as:

(Condition to be treated)

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

(Procedures)

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I (we) understand that my physician may discover other or different conditions which require additional procedures than those planned. I (we) authorize my physician, and any associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (we) understand that these qualified medical practitioners may be performing significant tasks related to the surgery such as opening or closing incisions, harvesting or dissecting tissue, altering tissue, implanting devices, tissue removal or photography during procedures.

☐ Initial

I (we) Do ☐ Do Not ☐ consent to the use of blood and blood products as considered necessary. *Benefits, risks, alternatives and the risks and benefits of alternatives have been discussed and I (we) have been given the opportunity to ask questions.*

**TEXAS MEDICAL DISCLOSURE**  
**Hematic and lymphatic system**

☐

**1. Transfusion of blood and blood components.**

1. Fever.
2. Transfusion reaction which may include failure or anemia
3. Heart failure
4. Hepatitis
5. AIDS (Acquired Immune Deficiency Syndrome)
6. Other infections



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**DISCLOSURE AND CONSENT -  
MEDICAL AND SURGICAL**



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Initial

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, such as the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I (we) also realize that the following specific risks and hazards may occur in connection with this particular procedure(s):

Initial

I (we) Do ☐ Do Not ☐ consent to have one or more manufacturer's technical representatives, as requested by my physician, in the room during the procedure. I understand that one or more representatives from the equipment and/or supply company for the products that the physician will use during my procedure, may be present for the procedure but will not perform any portion of the procedure. I further understand that all manufacturer's technical representatives present have confidentiality agreements and that none of the my personal health information will be disclosed to anyone other than my caregivers within this hospital.

I (we) consent to the disposal by hospital authorities of any tissue or parts which may be removed.

I (we) have been given the opportunity to ask questions about my current condition(s), the proposed procedure(s), the benefits, the likelihood of success, the possible problems related to recovery, the possible risks of nontreatment of my condition, and other alternative forms of treatment, and the risks and benefits of alternatives involved. I (we) understand that no warranty or guarantee has been made to me as to result or cure. Any professional/business relationship between my health care providers, the hospital and educational institutions has been explained to me.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents. I (we) believe that I (we) have sufficient information to give this informed consent and I (we) request the procedure(s) to be done.

Patient's Signature	Date	Time	Other Legally Responsible Person's Signature	Relationship	Date	Time
			<input type="checkbox"/> Medical City Plano, 3901 West 15th Street, Plano, TX 75075			
			<input type="checkbox"/> Other:			
Witness Signature/Title/Position	Date	Time	Witness Work Address			
Interpreter			Reason:			

I have provided the patient/parent/guardian with information on risks, benefits, and alternatives to treatment as outlined in the above within my area of expertise.

Physician Signature	Date	Time
Responsible for Procedure		

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## Anesthesia Consent

**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia 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 that you may give or withhold your consent to the anesthesia/analgesia.

I (we) understand that anesthesia involves additional risks and hazards, but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that serious but rare complications may result from the use of any anesthetic including respiratory problems, drug reactions, paralysis, brain damage or even death.

I (we) voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers are necessary. Perioperative means the period shortly before, during or shortly after the procedure. I also understand that other complications may occur. Those complications include but are not limited to:

Check planned anesthesia/analgesia method(s) and have the patient/other legally responsible person initial.

- ☐ \_\_\_\_\_ **General Anesthesia** - injury to vocal cords, teeth, lips, eyes; awareness during the procedure; memory dysfunction/memory loss; permanent organ damage; brain damage.
- ☐ \_\_\_\_\_ **Regional Block Anesthesia/Analgesia** - nerve damage; persistent pain; bleeding/hematoma; infection; medical necessity to convert to general anesthesia; brain damage.
- ☐ \_\_\_\_\_ **Spinal Anesthesia/Analgesia** - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.
- ☐ \_\_\_\_\_ **Epidural Anesthesia/Analgesia** - nerve damage; persistent back pain; headache; infection; bleeding/epidural hematoma; chronic pain; medical necessity to convert to general anesthesia; brain damage.
- ☐ \_\_\_\_\_ **Monitored Anesthesia Care** - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.
- ☐ \_\_\_\_\_ **Deep Sedation** - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.
- ☐ \_\_\_\_\_ **Moderate Sedation** - memory dysfunction/memory loss; medical necessity to convert to general anesthesia; permanent organ damage; brain damage.
- ☐ \_\_\_\_\_ **OTHER** - Including possible complications (required): \_\_\_\_\_

### ADDITIONAL COMMENTS/RISKS:

- ☐ \_\_\_\_\_ **PRENATAL/EARLY CHILDHOOD ANESTHESIA** - potential long-term negative effects on memory, behavior, and learning with prolonged or repeated exposure to general anesthesia/moderate sedation during pregnancy and in early childhood.

Additional Comments/Risks: \_\_\_\_\_

I (we) have been given an opportunity to ask questions about my condition, benefits, risks, alternatives and the risks and benefits of alternative forms of anesthesia and treatment, risks and benefits of non-treatment, the procedures to be used, and the risks and hazards involved. I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me, 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 the contents.

I (we) understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Other Legally Responsible Person's Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

☐ Medical City Plano, 3901 West 15th Street, Plano, TX 75075

☐ Other: \_\_\_\_\_

Witness Signature/Title/Position \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Witness Work Address \_\_\_\_\_

Reason: \_\_\_\_\_

Interpreter \_\_\_\_\_

The risks, benefits, and alternatives have been explained and the patient/family understand(s) and agree(s) to the procedure.

Signature of Physician / Proceduralist responsible for Anesthesia: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



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### DISCLOSURE AND CONSENT - MEDICAL AND SURGICAL



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# LIST A TEXAS MEDICAL DISCLOSURE

Rev. 2022

Procedures requiring full disclosure (List A). The following treatments and procedures require full disclosure by the physician or health care provider to the patient or person authorized to consent for the patient.

## Patient to initial appropriate square.

### RADIOLOGY

☐ **(1) Splenoportography (needle injection of contrast media into the spleen).**

- (A) All associated risks as listed under subsection (b)(2)(B) of this section.  
(B) Injury to the spleen requiring blood transfusion and/or removal of the spleen.

☐ **(2) Chemoembolization.**

- (A) All associated risks as listed under subsection (b)(2)(B) of this section.  
(B) Tumor lysis syndrome (rapid death of tumor cells, releasing their contents which can be harmful).  
(C) Injury to or failure of liver (or other organ in which tumor is located).  
(D) Risks of the chemotherapeutic agent(s) utilized.  
(E) Cholecystitis (inflammation of the gallbladder) (for liver or other upper GI embolizations).  
(F) Abscess (infected fluid collection) in the liver or other embolized organ requiring further Intervention.  
(G) Biloma (collection of bile in or near the liver requiring drainage) (for liver embolizations).

☐ **(3) Radioembolization.**

- (A) All associated risks as listed under subsection (b)(2)(B) of this section.  
(B) Tumor lysis syndrome (rapid death of tumor cells, releasing their contents which can be harmful).  
(C) Injury to or failure of liver (or other organ in which tumor is located).  
(D) Radiation complications: pneumonitis (inflammation of lung) which is potentially fatal; inflammation of stomach, intestines, gallbladder, pancreas; stomach or intestinal ulcer; scarring of liver.

☐ **(4) Thermal and other ablative techniques for treatment of tumors (for curative intent or palliation) including radiofrequency ablation, microwave ablation, cryoablation, and high intensity focused ultrasound (HIFU).**

- (A) Injury to tumor-containing organ or adjacent organs/structures.  
(B) Injury to nearby nerves potentially resulting in temporary

- or chronic (continuing) pain and/or loss of use and/or feeling.  
(C) Failure to completely treat tumor.

☐ **(5) TIPS (Transjugular Intrahepatic Portosystemic Shunt) and its variants such as DIPS (Direct Intrahepatic Portocaval Shunt).**

- (A) All associated risks as listed under subsection (b)(2)(B) - (D) of this section.  
(B) Hepatic encephalopathy (confusion/decreased ability to think).  
(C) Liver failure or injury.  
(D) Gallbladder injury.  
(E) Hemorrhage (severe bleeding).  
(F) Recurrent ascites (fluid building up in abdomen) and/or bleeding.  
(G) Kidney failure.  
(H) Heart failure.  
(I) Death.

☐ **(6) Myelography/Lumbar Puncture.**

- (A) Chronic (continuing) pain.  
(B) Nerve injury with loss of use and/or feeling.  
(C) Transient (temporary) headache, nausea, and/or vomiting.  
(D) Numbness.  
(E) Seizure.

☐ **(7) Percutaneous abscess/fluid collection drainage (percutaneous abscess/seroma/lymphocele drainage and/or sclerosis (inclusive of percutaneous, transgluteal, transrectal and transvaginal routes)).**

- (A) Sepsis (infection in the blood stream), possibly resulting in shock (severe decrease in blood pressure).  
(B) Injury to nearby organs.  
(C) Hemorrhage (severe bleeding).  
(D) Infection of collection which was not previously infected, or additional infection of abscess.

☐ **(8) Procedures utilizing prolonged fluoroscopy.**

- (A) Skin injury (such as epilation (hair loss), burns, or ulcers).  
(B) Cataracts (for procedures in the region of the head).

☐ **(9) Vertebroplasty/kyphoplasty.**

- (A) Nerve/spinal cord injury.  
(B) Need for emergency surgery  
(C) Embolization of cement (cement passes into blood vessels and possibly all the way to the lungs).  
(D) Collapse of adjacent vertebrae (bones in spine).  
(E) Leak of cerebrospinal fluid (fluid around the brain and spinal cord).  
(F) Pneumothorax (collapsed lung).  
(G) Failure to relieve pain.  
(H) Rib fracture.



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### RADIOLOGY AND RADIOLOGY PROCEDURES



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**(10) Percutaneous nephrostomy/stenting/stone removal.**

- (A) Pneumothorax or other pleural complications (collapsed lung or filling of the chest cavity on the same side with fluid).
- (B) Septic shock/bacteremia (infection of the blood stream with possible shock/severe lowering of blood pressure) when pyonephrosis (infected urine in the kidney) present.
- (C) Bowel (intestinal) injury.



**(11) Lung biopsy (removal of small piece of tissue from inside of lung).**

- (A) Air Leak with pneumothorax (leak of air from lung to inside of chest causing the lung to collapse) of chest tube or repeat surgery.
- (B) Hemothorax (blood in the chest around the lung) possibly requiring additional procedures.
- (C) Hemoptysis (coughing up blood which can result in trouble breathing and the need to be placed on a ventilator or breathing machine and oxygen).



**(12) Hepatobiliary drainage/intervention including percutaneous transhepatic cholangiography, percutaneous biliary drainage, percutaneous cholecystostomy, biliary stent placement (temporary or permanent), biliary stone removal/therapy.**

- (A) Leakage of bile at the skin site or into the abdomen with possible peritonitis (inflammation of the abdominal lining and pain or if severe can be life threatening).
- (B) Pancreatitis (inflammation of the pancreas).
- (C) Hemobilia (bleeding into the bile ducts).
- (D) Cholangitis, cholecystitis, sepsis (inflammation/infection of the bile ducts, gallbladder or blood).
- (E) Pneumothorax (collapsed lung) or other pleural complications (complication involving chest cavity).



**(13) Selective salpingography and tubal reconstruction.**

- (A) Perforation (hole) created in the uterus or Fallopian tube.
- (B) Future ectopic pregnancy (pregnancy outside of the uterus).
- (C) Pelvic infection.



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**RADIOLOGY AND RADIOLOGY PROCEDURES**



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