

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)

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)

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



3901 West 15th Street
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(972) 596-6800

**DISCLOSURE AND CONSENT -
MEDICAL AND SURGICAL**



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PATIENT IDENTIFICATION

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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DISCLOSURE AND CONSENT -
MEDICAL AND SURGICAL

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PATIENT IDENTIFICATION

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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PATIENT IDENTIFICATION

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.

NERVOUS SYSTEM TREATMENTS AND PROCEDURES

- ☐ (1) **Craniotomy, craniectomy or cranioplasty.**
(A) Loss of brain function such as memory and/or ability to speak.
(B) Recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse).
(C) Stroke (damage to brain resulting in loss of one or more functions).
(D) Loss of senses (blindness, double vision, deafness, smell, numbness, taste).
(E) Weakness, paralysis, loss of coordination.
(F) Cerebrospinal fluid leak with potential for severe headaches.
(G) Meningitis (infection of coverings of brain and spinal cord).
(H) Brain abscess.
(I) Persistent vegetative state (not able to communicate or interact with others).
(J) Hydrocephalus (abnormal fluid buildup causing pressure in the brain).
(L) Need for permanent breathing tube and/or permanent feeding tube.

- ☐ (2) **Cranial nerve operations.**
(A) Weakness, numbness, impaired muscle function or paralysis.
(B) Recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse).
(D) New or different pain.
(E) Stroke (damage to brain resulting in loss of one or more functions).
(F) Persistent vegetative state (not able to communicate or interact with others).
(G) Loss of senses (blindness, double vision, deafness, smell, numbness, taste).
(H) Cerebrospinal fluid leak with potential for severe headaches.
(I) Meningitis (infection of coverings of brain and spinal cord).
(J) Need for prolonged nursing care.
(K) Need for permanent breathing tube and/or permanent feeding tube.

- ☐ (3) **Spine operation, including laminectomy, decompression, fusion, internal fixation or procedures for nerve root or spinal cord compression; diagnosis; pain; deformity; mechanical instability; injury; removal of tumor, abscess or hematoma (excluding coccygeal operations).**
(A) Weakness, pain, numbness or clumsiness.
(B) Impaired muscle function or paralysis.
(C) Incontinence, impotence or impaired bowel function (loss of bowel/bladder control and/or sexual function).
(D) Migration of implants (movement of implanted devices).
(E) Failure of implants (breaking of implanted devices).
(F) Adjacent level degeneration (breakdown of spine above and/or below the level treated).
(G) Cerebrospinal fluid leak with potential for severe headaches.
(H) Meningitis (infection of coverings of brain and spinal cord).
(I) Recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse).
(J) Unstable spine (abnormal movement between bones and/or soft tissues of the spine).

- ☐ (4) **Peripheral nerve operation; nerve grafts, decompression, transposition or tumor removal; neuroorrhaphy, neurectomy or neurolysis.**
(A) Numbness.
(B) Impaired muscle function.
(C) Recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse).
(D) Continued, increased or different pain.
(E) Weakness.

- ☐ (5) **Transphenoidal hypophysectomy or other pituitary gland operation.**
(A) Cerebrospinal fluid leak with potential for severe headaches.
(B) Necessity for hormone replacement.
(C) Recurrence or continuation of the condition that required this operation.
(D) Deformity or perforation of nasal septum (hole in wall between the right and left halves of the nose).
(E) Facial nerve injury resulting in disfigurement (loss of nerve function controlling muscles in face).

- ☐ (6) **Cerebrospinal fluid shunting procedure or revision.**
(A) Shunt obstruction (blockage of shunt/tubing causing it to stop draining adequately).
(B) Malposition or migration of shunt/tubing (improper positioning or later movement of shunt/tubing causing it to stop draining adequately).
(C) Seizures (uncontrolled nerve activity).
(D) Recurrence or continuation of brain dysfunction.
(E) Injury to internal organs of the chest or abdomen.
(F) Brain injury.
(G) Stroke (damage to brain resulting in loss of one or more functions).



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DISCLOSURE AND CONSENT NERVOUS SYSTEM TREATMENTS AND PROCEDURES



PATIENT IDENTIFICATION

- (H) Persistent vegetative state (not able to communicate or interact with others).
- (I) Loss of senses (blindness, double vision, deafness, smell, numbness, taste).
- (J) Cerebrospinal fluid leak with potential for severe headaches.
- (K) Meningitis (infection of coverings of brain and spinal cord).
- (L) Need for prolonged nursing care.
- (M) Need for permanent breathing tube and/or permanent feeding tube.



(7) Elevation of depressed skull fracture.

- (A) Loss of brain function such as memory and/or ability to speak.
- (B) Recurrence, continuation or worsening of the condition that required this operation (no improvement or symptoms made worse).
- (C) Loss of senses (blindness, double vision, deafness, smell, numbness, taste).
- (D) Weakness, paralysis, loss of coordination.
- (E) Cerebrospinal fluid leak with potential for severe headaches.
- (F) Meningitis (infection of coverings of brain and spinal cord).
- (G) Brain abscess.
- (H) Persistent vegetative state (not able to communicate or interact with others).
- (I) Seizures (uncontrolled nerve activity).
- (J) Need for permanent breathing tube and/or permanent feeding tube.



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PATIENT IDENTIFICATION

DISCLOSURE AND CONSENT
NERVOUS SYSTEM TREATMENTS
AND PROCEDURES



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