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:

_____

_____

_____

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):

_____

_____

_____

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.*

☐ Initial

Texas Medical Disclosure
HEMATIC AND LYMPHATIC SYSTEM

1. Transfusion of blood and blood components.

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

☐ 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):

_____

_____

_____

I (we) **Do** ☐ **Do Not** ☐ consent to have students watch my procedure with my doctor for medical education, with the exception of: _____

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 my personal health information will be disclosed to anyone other than my care givers within this hospital.

I (we) **Do** ☐ **Do Not** ☐ consent to my physician taking photographs during my procedure as long as my name or identity is not shown to anyone.

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.

Initials ☐

Patient's Signature _____ Date _____ Time _____

Other Legally Responsible Person's Signature _____ Relationship _____ Date _____ Time _____

☐ Medical City Plano, 3901 West 15th Street, Plano, Texas 75075
☐ 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.

Date: _____ **Time:** _____ **Physician Signature:** ***X*** _____ _____

Physician Identifier

Medical City Plano
3901 West 15th Street
Plano, Texas 75075
(972) 596-6800

PATIENT IDENTIFICATION

DISCLOSURE AND CONSENT: UNIVERSAL PROCEDURE(S) BLOOD/ BLOOD PRODUCT ADMINISTRATION