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

Reason: _____

Interpreter _____

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

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 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 as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

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

I understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, drug reactions, nerve damage, cardiac arrest, brain damage, paralysis, or death.

I also understand that other complications may occur. Those complications include but are not limited to:

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

☐ Initial
General Anesthesia - Injury to Vocal Cords, Teeth, Lips, Eyes; Awareness during the procedure; Memory Dysfunction/Memory Loss; Permanent Organ Damage; Brain Damage.

☐ Initial
Regional Block Anesthesia/Analgesia - Nerve Damage; Persistent Pain; Bleeding/Hematoma; Infection; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial
Spinal Anesthesia/Analgesia - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial
Epidural Anesthesia/Analgesia - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial
Deep Sedation - Memory Dysfunction/Memory Loss; Medical necessity to convert to general anesthesia; Permanent Organ Damage; Brain Damage.

☐ Initial
Moderate Sedation - Memory Dysfunction/Memory Loss; Medical necessity to convert to general anesthesia; Permanent Organ Damage; Brain Damage.

Additional comments/risks:

☐ Initial
Prenatal/Early Childhood Anesthesia- Potential long-term negative effects on memory, behavior, and learning with prolonged or repeated exposure to general anesthesia/moderate sedation/deep sedation during pregnancy and in early childhood.

I (we) have been given an opportunity to ask questions about my anesthesia/analgesia methods, the procedures to be used, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I (we) believe that 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.

Initials ☐

Patient's Signature Date Time

Other Legally Responsible Person's Signature Relationship Date Time

☐ Medical City Plano, 3901 West 15th Street, Plano, TX 75075
☐ Medical City Frisco, 5500 Frisco Square Blvd., Frisco, TX 75034
☐ 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

Physician / Proceduralist Responsible for Anesthesia: ***X*** _____ Date Time

Physician Identifier

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

PATIENT IDENTIFICATION

DISCLOSURE AND CONSENT:
ANESTHESIA and/or PERIOPERATIVE PAIN MANAGEMENT

* T R E A T *

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.

NOTICE: Refusal to consent to a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect your right to future care or treatment.

I (we) voluntarily request Dr. _____ as my physician, 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:

_____

_____

_____

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):

- ☐ Abdominal total hysterectomy
- ☐ Vaginal total hysterectomy
- ☐ Abdominal supracervical hysterectomy
- ☐ Removal of fallopian tubes and ovaries
  - ☐ unilateral ☐ bilateral
- ☐ Additional procedure: _____
- ☐ Laparoscopically assisted vaginal hysterectomy
- ☐ Laparoscopic supracervical hysterectomy
- ☐ Laparoscopic total hysterectomy
- ☐ Robotic assisted supracervical hysterectomy
- ☐ Robotic assisted total hysterectomy

☐ I (we) understand that a hysterectomy is a removal of the uterus through an incision in the lower abdomen or vagina. I (we) also understand that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina.

☐ I (we) understand the use of laparoscopic and other equipment will be used through small incisions in the abdomen to remove the uterus, with or without the cervix. I also understand that additional surgery may be necessary to remove or repair other organs, including ovary, tube, appendix, bladder, rectum, or vagina.

I (we) understand that the hysterectomy is permanent and not reversible. I (we) understand that I will not be able to become pregnant or bear children. I (we) understand that I have the right to seek a consultation from a second physician.

I (we) understand that my physician may discover other or different conditions which require additional 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.

☐ Initial

I (we) **Do**☐ **Do Not**☐ 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:

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

I (we) understand that no warranty or guarantee has been made to me as a result or cure.
I (we) have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of no treatment, the procedures to be used, and the risks and hazards involved and I (we) believe that I (we) have sufficient information to give this informed consent.

Medical City Plano

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

PATIENT IDENTIFICATION

DISCLOSURE AND CONSENT: HYSTERECTOMY

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

I (we) **Do**☐ **Do Not**☐ consent to students and/or technical representatives to watch my procedure with my doctor for medical education or product use, with the exception of: _____

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) certify this form has been fully explained to me (us), that I (we) have read it or have had read it to me (us), that the blank spaces have been filled in, and that I (we) understand its content. 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 are the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure (check applicable procedure):

☐ **ABDOMINAL HYSTERECTOMY**	☐ **VAGINAL HYSTERECTOMY**
1. Uncontrollable leakage of urine	1. Uncontrollable leakage of urine
2. Injury to the bladder	2. Injury to the bladder
3. Sterility	3. Sterility
4. Injury to the tube (ureter) between the kidney and the bladder	4. Injury to the tube (ureter) between the kidney and the bladder
5. Injury to the bowel and/or intestinal obstruction	5. Injury to the bowel and/or intestinal obstruction
6. Possible fistula formation (an opening between two organs)	6. Possible fistula formation (an opening between two organs)
7. Possible vaginal wall dehiscence (opening)	7. Possible vaginal wall dehiscence (opening)
8. Possible cyclic bleeding if cervix remains (in supracervical hysterectomy)	8. Completion of operation by abdominal incision

☐ For **LAPROSCOPICALLY / ROBOTIC ASSISTED HYSTERECTOMY** risks include: sterility, uncontrollable leakage of urine, injury to the bladder or the tube (ureter) between the kidney and the bladder, injury to the bowel and/or intestinal obstruction, damage to the intra-abdominal structures (bowel, bladder, blood vessels, or nerves), possible fistula formation (an opening between two organs), possible vaginal wall dehiscence (opening), intra-abdominal abscess and infectious complications, laparoscopy tool (trocar) site complications (hematoma "blood/clot" / bleeding, leakage of fluid, or hernia formation), possible nerve damage to arms, legs, or back due to positioning, possible completion of the operation by abdominal incision, cardiac dysfunction, possible cyclic bleeding if cervix remains (in supracervical hysterectomy)

Additional risks: _____

Initials ☐

_____ Patient's Signature Date Time

_____ Witness Signature/Title/Position Date Time

_____ Interpreter

_____ Other Legally Responsible Person's Signature Relationship Date Time

☐ Medical City Plano, 3901 West 15th Street, Plano, Texas 75075
☐ Other: _____ Witness Work Address

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: HYSTERECTOMY

* T R E A T *

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 certain complications may result from the use of any anesthetic including respiratory problems, drug reactions, paralysis, brain damage or even death.

☐ Initial
General Anesthesia - Injury to Vocal Cords, Teeth, Lips, Eyes; Awareness during the procedure; Memory Dysfunction/Memory Loss; Permanent Organ Damage; Brain Damage.

☐ Initial
Regional Block Anesthesia/Analgesia - Nerve Damage; Persistent Pain; Bleeding/Hematoma; Infection; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial
Spinal Anesthesia/Analgesia - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial
Epidural Anesthesia/Analgesia - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial
Monitored Anesthesia Care or Sedation/Analgesia - Memory Dysfunction/Memory Loss; Medical necessity to convert to general anesthesia; Permanent Organ Damage; Brain Damage.

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.

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: _____

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

Physician / Proceduralist Responsible for Anesthesia: ***X*** _____ Date _____ Time _____ ***Physician Identifier***

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

PATIENT IDENTIFICATION

HYSTERECTOMY: ANESTHESIA CONSENT