

**The University of Texas
Southwestern Medical Center
at Dallas**

Ambulatory Services

**DISCLOSURE AND
OPERATIVE CONSENT**

Pt. Name: _____

Address: _____

City State Zip

MRN: _____

DOB: _____

SSN: _____ SEX: _____

DOS: _____

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. This will allow you to decide 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 that you give or withhold your consent to the procedure. You have the right to refuse any proposed operation or procedure anytime prior to its performance.

I 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 as:

I understand that the following procedure will be performed _____

I 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.

I consent to the use of blood and blood products as deemed necessary. I understand that there are risks related to transfusion, however unlikely, including but not limited to the following: allergic reaction, fever, heart failure, infection by bacteria, parasites or viruses, including malaria, hepatitis, and AIDS, and possibility of blood incompatibility, which can result in severe complications, including kidney failure, and rarely death.

I understand that no warranty or guarantee has been made to me as a 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 understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I realize that the type of anesthesia may have to be changed, possibly without explanation to me.

I understand that certain complications may result from the use of any anesthetic. These include respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards that may result from the use of general anesthetics range from minor discomfort to injury of the vocal cords, teeth or eyes. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

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

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understood its contents.

Date: _____

Time: _____

Patient / Other Legally Responsible Person Signature

Physician

Date

Witness: Name (Please Print)
5323 Harry Hines
Dallas, Texas 75390

Signature