Patient Label Here

Date _____

Resident and Nurse Consent/Orders Checklist

Instructions for form completion

Note: Enter "not applicable" or "none" in spaces as appropriate. Consent may not contain blanks.

Section 1: Enter name of physician(s) responsible for procedure and patient's condition in lay terminology. Specific location of procedure must be indicated (e.g. right hand, left inguinal hernia) & **may not be abbreviated.**

Section 2: Enter name of procedure(s) to be done. Use lay terminology.

Section 3: The scope and complexity of conditions discovered in the operating room requiring additional surgical procedures should be specific to diagnosis.

Section 5: Enter risks as discussed with patient.

A. Risks for procedures on List A must be included. Other risks may be added by the Physician.
B. Procedures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be discussed with the patient. For these procedures, risks may be enumerated or the phrase: "As discussed with patient" entered.

Section 8: Enter any exceptions to disposal of tissue or state "none".

Section 9: An additional permit with patient's consent for release is required when a patient may be identified in photographs or on video.

Provider Attestation: Enter date, time, printed name and signature of provider/agent.

Patient Signature: Enter date and time patient or responsible person signed consent.

Witness Signature: Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature

Performed Date: Enter date procedure is being performed. In the event the procedure is NOT performed on the date indicated, staff must cross out, correct the date and initial.

If the patient does **not** consent to a specific provision of the consent, the consent should be rewritten to reflect the procedure that the patient (authorized person) is consenting to have performed.

For additional information on informed consent policies, refer to policy SPP PC-17.

Consent

☐ Name of the procedure (lay term)	☐ Right or left indicated when applicable
☐ No blanks left on consent	☐ No medical abbreviations

Orders

☐ Procedure Date	☐ Procedure
☐ Diagnosis	☐ Signed by Physician & Name stamped

Nurse_____ Resident_____ Department _____

THIS FORM IS NOT PART OF THE MEDICAL RECORD

Patient Label Here

DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

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.

1. I (we) voluntarily request Doctor(s)_____ as my physician(s), 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 **(lay terms):** A blood clot that is keeping blood from flowing to/through:

2. I (we) understand that the following surgical, medical, and/or diagnostic **procedures** are planned for me and I (we) voluntarily consent and authorize these **procedures (lay terms):** TPA Infusion - use a medicine to break up the clot in my _____ and restore circulation

Please check appropriate box: ☐ Right ☐ Left ☐ Bilateral ☐ Not Applicable

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

4. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.

5. 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 is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following hazards may occur in connection with this particular procedure: Pain, severe bleeding, infection, bruising at the site of injections or blood draws, allergic reactions, itching, breathing problems that require the need to mechanically ventilate, tracheostomy, stroke, heart attack, kidney failure, need to place a catheter into a major vein to provide for dialysis access or administration of medication , limb loss, clot moving up or down causing severe problems in other organs

6. I (we) understand that all Do Not Resuscitate (DNR) / Do Not Intubate (DNI) statuses are suspended during the perioperative period and until the post anesthesia recovery period is complete.

7. 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 reaction, paralysis, brain damage or even death. Monitored Anesthesia Care (MAC) or Conscious Sedation includes additional risks of permanent organ damage, memory dysfunction/memory loss, and the potential to convert to a general anesthetic if the sedation is not adequate and may be used in conjunction with a local anesthetic. I (we) also realize that the following hazards may occur in connection with this particular procedure related to anesthesia: Allergic reaction to medication, breathing problems, depression, choking on stomach contents (aspiration), cardiac or respiratory arrest, inadequate sedation, need for extended observation in the hospital.

Patient Label Here

TPA Infusion (cont.)

8. I (we) authorize Hospital to preserve for educational and/or research purposes, or for use in grafts in living persons, or to otherwise dispose of any tissue, parts or organs removed except: NONE _____.

9. I (we) consent to the taking of still photographs, motion pictures, videotapes, or closed circuit television during this procedure.

10. I (we) give permission for a corporate medical representative to be present during my procedure on a consultative basis.

11. I (we) have been given an 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, potential benefits, risks, or side effects, including potential problems related to recuperation and the likelihood of achieving care, treatment, and service goals. I (we) believe that I (we) have sufficient information to give this informed consent.

12. I (we) certify this form has been fully explained to me and 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 its contents.

IF I (WE) DO NOT CONSENT TO ANY OF THE ABOVE PROVISIONS, THAT PROVISION HAS BEEN CORRECTED.

I have explained the procedure/treatment, including anticipated benefits, significant risks and alternative therapies to the patient or the patient's authorized representative.

_____ _____ A.M. (P.M.) _____ _____

Date Time Printed name of provider/agent Signature of provider/agent

_____ _____ A.M. (P.M.)

Date Time

_____

*Patient/Other legally responsible person signature Relationship (if other than patient)

_____

*Witness Signature Printed Name

☐ OTHER Address: _____

Address (Street or P.O. Box) City, State, Zip Code

Date procedure is being performed: _____