DISCLOSURE AND CONSENT
MEDICAL CARE, DIAGNOSTIC, AND SURGICAL PROCEDURES

☐ Methodist Dallas Medical Center ☐ Methodist Charlton Medical Center ☐ Methodist Mansfield Medical Center
☐ Methodist Richardson Medical Center ☐ Methodist Midlothian Medical Center ☐ Methodist Southlake Medical Center
☐ Other ____

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your physician/health care provider any remaining questions you have before signing this form.

Description of Medical Care and Surgical or Diagnostic Procedure(s)

I voluntarily request my physician/health care provider___________________________ , and other health care providers, to treat my condition which is: ____

I also grant permission for physicians in post-graduate medical education training, personnel/students of medical, nursing and other clinical training programs affiliated with Methodist Health System to participate in the procedure(s) described below.

I understand that the following care/procedure(s) are planned for me:

Potential for Additional Necessary Care/Procedure(s)

I understand that during my care/procedure(s), my physician/health care provider may discover other conditions which require additional or different care/procedure(s) than originally planned.

I authorize my physicians/health care providers to use their professional judgment to perform the additional or different care/procedure(s) they believe are needed.

Use of Blood

Please check "Yes" or "No" and Initial: ☐Yes ☐No Initials ______

I consent to the use of blood and blood products as necessary for my health during the care/procedure(s) and during the remaining course of this hospitalization. The risks that may occur with the use of blood and blood products are:

1. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
2. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys, and immune system.
3. Severe allergic reaction, potentially fatal.
4. Bruising, swelling, and/or infection at the site where the needle is inserted into the vein.

If this consent is for blood products specifically authorized under an Emergency Use Authorization (EUA) by the Food and Drug Administration (FDA), I have been provided the FDA issued patient information fact sheet(s) as required by the FDA's EUA. ☐Yes ☐No ☐NA
Initials ______

Risks Related to this Care/Procedure(s)

Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the care/procedure(s) planned for me.

I understand that all care/procedure(s) involve some risks, ranging from minor to severe. These risks include infection, blood clots in veins, lungs or other organs, hemorrhage (severe bleeding), allergic reactions, poor wound healing, and death.

The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient's current health.

Risks of this care/procedure(s) include, but are not limited to **[include List A risks here and additional risks if any]**:

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DISPOSAL OF REMOVED TISSUE: I (we) authorize the Hospital to use its discretion to retain or dispose of any tissue(s) removed during any operation or procedure. For disposal refer to consent form # 40170 for amputation.
OBSERVATION OF PROCEDURE: I (we) consent to the admittance of observers during the operation or procedure

for the purpose of medical and allied health education.

PHOTOGRAPHING OR VIDEOTAPING OF PROCEDURE: I (we) ☐**do** ☐**do not** ______INITIALS consent to the photographing or videotaping of the operations or procedures to be performed, including appropriate portions of my body, and the inclusion of such pictures in my medical record. In addition, I (we) consent to the use of such pictures for medical, scientific, or educational purposes, providing my identity is not revealed by the pictures or descriptive texts accompanying the pictures.

Granting of Consent for this Care/Procedure(s)

In signing below, I consent to the care/procedure(s) described above. I acknowledge the following:

- I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
- I have been given an opportunity to ask questions I may have about:
  1. Alternative forms of treatment, care, or service
  2. Risks of non-treatment,
  3. Steps that will occur during my care/procedure(s), and
  4. Risks and hazards involved in the care/procedure(s).
  5. Assistants needed in the procedure to perform delegated tasks under my supervision.
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

Patient/Other Legally Authorized Representative (signature required):

TYPE HERE

Print Name ______________________ Signature ______________________

(If Legally Authorized Representative, list relationship to Patient): ______________________

Date:______________________ Time:______________________A.M./P.M.

Witness:

TYPE HERE

Print Name ______________________ Signature ______________________

If MHS Employee serving as witness, please check appropriate box below for Witness address:

☐ **Methodist Dallas Medical Center** 1441 N. Beckley Ave., Dallas, TX 75203
☐ **Methodist Charlton Medical Center** 3500 W. Wheatland Rd., Dallas, TX 75237
☐ **Methodist Mansfield Medical Center** 2700 E. Broad St., Mansfield, TX 76063
☐ **Methodist Richardson Medical Center** 401 W. Campbell Rd., Richardson, Texas 75080
☐ **Methodist Richardson Medical Center** 2831 E. President George Bush Hwy Richardson, Texas 7508
☐ **Methodist Midlothian Medical Center** 1201 E. U.S. Highway 287 Midlothian, Texas 76065
☐ **Methodist Southlake Medical Center** 421 E. State Hwy 114, Southlake, TX 76092

I certify that the patient/parent/guardian/or other legally responsible person has been provided information on the risks and hazards, benefits and alternatives to treatment as outlined above, had questions within my area of expertise answered and has given consent.

______________________ Date ____________ Time ________A.M./P.M.

Signature of Physician performing procedure

Translation of document (if applicable) provided by:

______________________ ______________________

Printed Name of Translator Agency/Department for Contacting Translator