Fort Bend Surgical Associates

2525 W. Bellfort, Suite 160
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Tel (713)664-2800
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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.

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 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 procedures: ______________________________
____
____

I (we) understand that my physician may discover other or 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.

______ I (we) do consent to the use of blood and blood products as deemed necessary.
Initial

______ I (we) do not consent to the use of blood and blood products as deemed necessary.
Initial

I (we) understand that no warranty or guarantee has been made to me as to 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 (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 risks and hazards may occur in connection with the particular procedure:

1) Pain, weakness or clumsiness
2) Impaired muscle function
3) Nausea and/or vomiting
4) Bleeding
5) Infection
6) Allergic reaction to medicine
7) Transient headache
8) Increased or unrealized pain

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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. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

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, and 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 (us), 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.

Date: ______________________________ Time: ________________________________ A.M. P.M.

____
Signature of patient or other legally responsible person

____
Signature of witness