Baylor Scott & White HEALTH

DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

This form is designed with the requirements promulgated by the Texas Medical Disclosure Panel

Patient Identification

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, residents, students and/or other health care providers as they may deem necessary at this or any other Baylor Scott & White Health Facility, 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:

Use of Laparoscopic Power Morcellation (medical device)

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, residents, students and/or other health care providers as they may deem necessary at this or any other Baylor Scott & White Health Facility, to perform such other procedures which are advisable in their professional judgment.

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

I (we) understand that no warranty or guarantee has been made to me as to 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 (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 this particular procedure:

1. **Uterine tissue may contain unsuspected cancer. The use of laparoscopic power morcellators during fibroid surgery may spread cancer, and decrease your long-term survival.**

2. **Undiagnosed cancer(s) including, but not limited to, gynecologic cancers.**

3. **If cancer is present and the primary site is unknown:**
   a. **an increase in the likelihood of cancer spread within the abdomen and pelvis;**
   b. **the potential for a worsened course and outcome;**
   c. **increased difficulty in making a definitive diagnosis and accurate staging; and/or**
   d. **additional surgery or treatment.**

4. **If benign tissue is present, viable tissue may spread to another site(s) that may require additional surgery or treatment.**

5. **If an intraperitoneal bag is used:**
   a. **insufficient bag size;**
   b. **disruption of bag by morcellator; and / or**
   c. **reduced visualization.**

I (we) also understand that the alternative to the use of power morcellation includes an open (non-laparoscopic) procedure.

For gynecological procedures, I (we) further understand that the alternatives to the use of power morcellation include the removal of intact tissue through mini-laparotomy, laparotomy, or colpotomy incisions, or by total abdominal hysterectomy, vaginal hysterectomy, or laparoscopic vaginal hysterectomy.

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, blindness, 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, lips or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

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I (we) understand that the effects of anesthesia and/or the planned and additional procedures may last several hours and that I (we) should refrain from driving or operating any potentially hazardous equipment or vehicles for 24 hours, unless indicated otherwise by my (our) physician. Understanding the risks, I (we) agree a responsible person will accompany me (us) home after the procedure and that I (we) will report any occurrence of side effects or complications to the appropriate Scott & White personnel.

I (we) consent to the videotaping, photographing, and/or other recording of myself and/or the portion(s) of my body involved in my medical condition, diagnosis, treatment, operation(s) and/or procedure(s) for medical education, internal quality control, performance improvement, and/or other related uses. I understand that for the purposes listed above I have the right to request cessation of the recording or filming. I also understand that for those purposes I have the right to rescind consent for the use of the recordings, videotapes and/or photographs up until a reasonable time before the recording or film is used. I understand the recording or film is the property of Scott & White

I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of nontreatment, the procedures to be used, the risks and hazards involved, and all other provisions contained herein. I (we) believe all of my (our) questions have been answered to my (our) satisfaction 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, 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.

DATE: _____ TIME: _____ A.M. / P.M.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____ _____ _____
Signature Print Name Relationship to Patient

WITNESS/PHYSICIAN:

_____ _____
Signature Print Name

_____
Address

_____
City, State, Zip code

Disclosure and Consent, Anesthesia and/or Perioperative Pain Management (Analgesia) **consent form must be reviewed and signed by anesthesia provider (i.e., anesthesiologist, CRNA, or operating practitioner who orders the perioperative sedation/analgesia if anesthesia provider will not be providing anesthesia services), if applicable.**