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 as he/she may deem necessary (for example anesthesia providers, educational assistants, and other health care providers who are identified and their professional role explained to me) to treat my condition. My condition 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 procedure(s):

______________________________________________________________________________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________________________________________________________________________

I (we) understand that my physician may discover other or different conditions which require additional procedures than those planned. I (we) authorize my physician, and any associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment. I (we) understand that these qualified medical practitioners may be performing significant tasks related to the surgery such as opening or closing incisions, harvesting or dissecting tissue, altering tissue, implanting devices, tissue removal or photography during procedures.

☐ Initial
☐ Do ☐ Do Not ☐ consent to the use of blood and blood products as considered necessary.

Benefits, risks, alternatives and the risks and benefits of alternatives have been discussed and I (we) have been given the opportunity to ask questions.

☐ Initial

Texas Medical Disclosure
HEMATIC AND LYMPHATIC SYSTEM

1. Transfusion of blood and blood components.
   1. Fever.
   2. Transfusion reaction which may include kidney failure or anemia.
   3. Heart failure.
   4. Hepatitis.
   5. AIDS (Acquired Immune Deficiency Syndrome).
   6. Other infections.
I (we) Do □ Do Not □ consent to have one or more manufacturer's technical representatives, as requested by my physician, in the room during the procedure. I understand that one or more representatives from the equipment and/or supply company for the products that the physician will use during my procedure, may be present for the procedure but will not perform any portion of the procedure. I further understand that all manufacturer’s technical representatives present have confidentiality agreements and that none of my personal health information will be disclosed to anyone other than my care givers within this hospital.

I (we) Do □ Do Not □ consent to my physician taking photographs during my procedure as long as my name or identity is not shown to anyone.

I (we) consent to the disposal by hospital authorities of any tissue or parts which may be removed.

I (we) have been given the opportunity to ask questions about my current condition(s), the proposed procedure(s), the benefits, the likelihood of success, the possible problems related to recovery, the possible risks of nontreatment of my condition, and other alternative forms of treatment, and the risks and benefits of alternatives involved. I (we) understand that no warranty or guarantee has been made to me as to result or cure. Any professional/business relationship between my health care providers, the hospital and educational institutions has been explained to me.

I (we) certify this form has been fully explained to me, 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. I (we) believe that I (we) have sufficient information to give this informed consent and I (we) request the procedure(s) to be done.

I (we) Do □ Do Not □ consent to have students watch my procedure with my doctor for medical education, with the exception of: ________________________________

I (we) certify this form has been fully explained to me, 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. I (we) believe that I (we) have sufficient information to give this informed consent and I (we) request the procedure(s) to be done.

I have provided the patient/parent/guardian with information on risks, benefits, and alternatives to treatment as outlined in the above within my area of expertise.

Date: ____________ Time: ____________ Physician Signature: X

I (we) Do □ Do Not □ consent to have students watch my procedure with my doctor for medical education, with the exception of: ________________________________

I (we) Do □ Do Not □ consent to my physician taking photographs during my procedure as long as my name or identity is not shown to anyone.

I (we) consent to the disposal by hospital authorities of any tissue or parts which may be removed.

I (we) have been given the opportunity to ask questions about my current condition(s), the proposed procedure(s), the benefits, the likelihood of success, the possible problems related to recovery, the possible risks of nontreatment of my condition, and other alternative forms of treatment, and the risks and benefits of alternatives involved. I (we) understand that no warranty or guarantee has been made to me as to result or cure. Any professional/business relationship between my health care providers, the hospital and educational institutions has been explained to me.

I (we) certify this form has been fully explained to me, 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. I (we) believe that I (we) have sufficient information to give this informed consent and I (we) request the procedure(s) to be done.
ANESTHESIA CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia 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 may give or withhold your consent to the anesthesia/analgesia.

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 reactions, paralysis, brain damage or even death.

☐ Initial General Anesthesia - Injury to Vocal Cords, Teeth, Lips, Eyes; Awareness during the procedure; Memory Dysfunction/Memory Loss; Permanent Organ Damage; Brain Damage.

☐ Initial Regional Block Anesthesia/Analgesia - Nerve Damage; Persistent Pain; Bleeding/Hematoma; Infection; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial Spinal Anesthesia/Analgesia - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial Epidural Anesthesia/Analgesia - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.

☐ Initial Monitored Anesthesia Care or Sedation/Analgesia - Memory Dysfunction/Memory Loss; Medical necessity to convert to general anesthesia; Permanent Organ Damage; Brain Damage.

I (we) have been given an opportunity to ask questions about my condition, benefits, risks, alternatives and the risks and benefits of alternative forms of anesthesia and treatment, risks and benefits of non-treatment, the procedures to be used, and the risks and hazards involved. 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 the contents.

I (we) understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

Initials

<table>
<thead>
<tr>
<th>Patient's Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Legally Responsible Person's Signature</th>
<th>Relationship</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ The Medical Center of Lewisville, 500 West Main, Lewisville, TX 75057-3699</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other:</td>
<td>Witness Work Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reason:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I (we) consent to the disposal by hospital authorities of any tissue or parts which may be removed.

I (we) Do □ Do Not □ consent to students and/or technical representatives to watch my procedure with my doctor for medical education or product use, with the exception of: ____________________________

I (we) Do □ Do Not □ consent to my physician taking photographs during my procedure as long as my name or identity is not shown to anyone.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had read it to me (us), that the blank spaces have been filled in, and that I (we) understand its content. 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 are 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 (check applicable procedure):

### ABDOMINAL HYSTERECTOMY
1. Uncontrollable leakage of urine
2. Injury to the bladder
3. Sterility
4. Injury to the tube (ureter) between the kidney and the bladder
5. Injury to the bowel and/or intestinal obstruction
6. Possible fistula formation (an opening between two organs)
7. Possible vaginal wall dehiscence (opening)
8. Possible cyclic bleeding if cervix remains (in supracervical hysterectomy)

### VAGINAL HYSTERECTOMY
1. Uncontrollable leakage of urine
2. Injury to the bladder
3. Sterility
4. Injury to the tube (ureter) between the kidney and the bladder
5. Injury to the bowel and/or intestinal obstruction
6. Possible fistula formation (an opening between two organs)
7. Possible vaginal wall dehiscence (opening)
8. Completion of operation by abdominal incision

For LAPROSCOPICALLY / ROBOTIC ASSISTED HYSTERECTOMY risks include: sterility, uncontrollable leakage of urine, injury to the bladder or the tube (ureter) between the kidney and the bladder, injury to the bowel and/or intestinal obstruction, damage to the intra-abdominal structures (bowel, bladder, blood vessels, or nerves), possible fistula formation (an opening between two organs), possible vaginal wall dehiscence (opening), intra-abdominal abscess and infectious complications, laparoscopy tool (trocar) site complications (hematoma "blood/clot" / bleeding, leakage of fluid, or hernia formation), possible nerve damage to arms, legs, or back due to positioning, possible completion of the operation by abdominal incision, cardiac dysfunction, possible cyclic bleeding if cervix remains (in supracervical hysterectomy)

Additional risks: ____________________________

Initials

Patient's Signature
Date
Time

Other Legally Responsible Person's Signature
Relationship
Date
Time

Witness Signature/Title/Position
Date
Time

Witness Work Address

Reason: ____________________________

I have provided the patient/parent/guardian with information on risks, benefits, and alternatives to treatment as outlined in the above within my area of expertise.

Date: ___________ Time: ___________

Physician Signature: X

Medical Center of Lewisville
500 West Main
Lewisville, Texas 75057-3699

DISCLOSURE AND CONSENT: HYSTERECTOMY
ANESTHESIA CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended anesthesia/analgesia to be used so that you may make the decision whether or not to receive the anesthesia/analgesia 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 may give or withhold your consent to the anesthesia/analgesia.

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 reactions, paralysis, brain damage or even death.

- **General Anesthesia** - Injury to Vocal Cords, Teeth, Lips, Eyes; Awareness during the procedure; Memory Dysfunction/Memory Loss; Permanent Organ Damage; Brain Damage.
- **Regional Block Anesthesia/Analgesia** - Nerve Damage; Persistent Pain; Bleeding/Hematoma; Infection; Medical necessity to convert to general anesthesia; Brain Damage.
- **Spinal Anesthesia/Analgesia** - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.
- **Epidural Anesthesia/Analgesia** - Nerve Damage; Persistent Back Pain; Headache; Infection; Bleeding/Epidural Hematoma; Chronic Pain; Medical necessity to convert to general anesthesia; Brain Damage.
- **Monitored Anesthesia Care or Sedation/Analgesia** - Memory Dysfunction/Memory Loss; Medical necessity to convert to general anesthesia; Permanent Organ Damage; Brain Damage.

I (we) have been given an opportunity to ask questions about my condition, benefits, risks, alternatives and the risks and benefits of alternative forms of anesthesia and treatment, risks and benefits of non-treatment, the procedures to be used, and the risks and hazards involved. 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 the contents.

I (we) understand that no promises have been made to me as to the result of anesthesia/analgesia methods.

I (we) understand that the risks, benefits, and alternatives have been explained and the patient/family understand(s) and agree(s) to the procedure.

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**Physician / Proceduralist Responsible for Anesthesia: X**

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**The Medical Center of Lewisville, 500 West Main, Lewisville, TX 75057-3699**

**Interpreter**

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**HYSTERECTOMY: ANESTHESIA CONSENT**