TO OUR PATIENT:
This is a sample of a form you will be asked to sign at the hospital.
Please read it so you will know what information it contains.

"SPINE OPERATION"

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

DISCLOSURE & CONSENT
MEDICAL & 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 you may make the decision of 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: **SPINE__________ OPERATION____**

I (we) understand that any tissue removed during surgery will be disposed of in accordance with hospital policy. I (we) understand that my physician may discover other or different conditions, which may 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)** **(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 result of care.
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 procedure 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:
___________*PAIN, NUMBNESS OR CLUMSINESS____
___________*IMPAIRED MUSCLE FUNCTION, INCONTINENCE OR IMPOTENCE___________________________
___________*UNSTABLE SPINE____
___________*RECURRENCE OR CONTINUATION OF THE CONDITION THAT REQUIRED THE OPERATION_______________
___________*INJURY TO MAJOR BLOOD VESSELS____
___________*LEAKAG OF SPINAL FLUID REQUIRING_RE-OPERATION______________________________
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. 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 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 nontreatment, 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, 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.______________

____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE

____

WITNESS NAME

____

ADDRESS (STREET OR PO BOX) **CITY, STATE, ZIP CODE**