

PRMC DISCLOSURE AND CONSENT FOR MEDICAL, SURGICAL AND DIAGNOSTIC 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 for the procedure.*

I voluntarily request Dr. Sylvester G. Ramirez 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: **hypertrophy adenoids, adnoiditis**

I understand that the following surgical, medical and diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures: **adenoidectomy**

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I 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 (DO) pt _____ witness _____ (DO NOT) pt _____ witness _____ consent to the use of blood and blood products as deemed necessary. I understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections.

I 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 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 also realize that the following risks and hazards may occur in connection with this particular procedure(s):

SEE ATTACHED PAGE FOR RISKS AND HAZARDS FOR LIST A OR LIST B PROCEDURES

OR

RISKS AS EXPLAINED TO ME BY MY PHYSICIAN **pain, risk of infection, change in voice, fever, sore throat, need for further surgery**

I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedure. I realize the anesthesia may have to be changed possibly without explanation to me. I 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 understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I 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 believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blanks spaces have been filled in and that I understand its contents.

DATE _____ TIME _____

PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON SIGN (RELATIONSHIP)

WITNESS (Print and signature)

1001 Water Street, Ste D-100

WORK ADDRESS

Kerrville, TX. 78028

CITY, STATE, ZIP CODE

PHYSICIAN CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the proposed procedure/operation. I have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian understands what I have explained and has consented to undergo the proposed procedure/operation.

Physician signature _____ Date _____ Time _____