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

_____

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) (DO NOT)** 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):
RISKS AS EXPLAINED TO ME BY MY PHYSICIAN_____

Bleeding
Infection
Pneumothorax
Dental Damage

I understand that a sedative medication may be administered to allow me to tolerate the procedure by relieving anxiety, discomfort or pain. The risks of sedation medication include **allergic reaction, loss of protective reflexes and cardiac or respiratory depression that could result in brain damage, cardiac arrest, or death.**

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)

551 Hill Country Drive. Kerrville, TX 78028

_____ _____ _____
WITNESS (Print and signature) WORK ADDRESS 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_____

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