# DISCLOSURE AND CONSENT FOR NASAL SEPTOPLASTY

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or

surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your physician/health care provider any remaining questions you have before signing this form.			
<b>Description of Medical Care and Surgical Procedure(s)</b> I voluntarily request my physician/health care provider providers, to treat my condition which is:	and other health care		
(Diagnosis)			
understand that the following care/procedure(s) are planned for me (	patient/other legally responsible person initial):		
□ Subcutaneous Resection of the Nasal Septum			
□ Nasal Septoplasty			
Potential for Additional Necessary Care/Procedure(s)			
l understand that during my care/procedure(s) my physician/health car additional or different care/procedure(s) than originally planned.	e provider may discover other conditions which require		
l authorize my physicians/health care providers to use their profession care/procedure(s) they believe are needed.	al judgment to perform the additional or different		
Use of Blood - Please initial "Yes" or "No":			
permanent impairment.			
Photographing or Videotaping - Please initial "Yes" or "No":			
Yes No I consent to the photographing or videotaping of the appropriate portions of my body, for medical, scient revealed by descriptive texts accompanying the pi	ntific or educational purposes, providing my identity is not		
Manufacturer's Technical Representatives - Please initial "Yes" or "	No":		
Yes No I 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 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 caregivers with the hospital.			
Yes No I consent to the disposal by hospital authorities of	any tissue or parts which may be removed.		
Medical City    11990 N Central Expy,      Heart & Spine Hospitals    11990 N Central Expy,      A Campus of Medical City Dallas    (972) 940-8000	NT IDENTIFICATION		



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### Risks Related to this Care/Procedure(s)

Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the care/procedure(s) planned for me.

I understand that all care/procedure(s) involve some risks, ranging from minor to severe. These risks include infection, blood clots in veins, lungs or other organs, hemorrhage (severe bleeding), allergic reactions, poor wound healing, and death.

The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient's current health.

Risks of this care/procedure(s) include, but are not limited to [include additional risks if any]:

- · Persistence, recurrence or worsening of the obstruction
- · Perforation of the nasal septum (hole in wall between the right and left halves of the nose) with dryness and crusting
- External deformity of the nose

### Granting of Consent for this Care/Procedure(s)

In signing below, I consent to the care/procedure(s) described above. I acknowledge the following:

- I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
- · I have been given an opportunity to ask questions I may have about:
  - 1. Alternative forms of treatment,
  - 2. Risks of non-treatment,
  - Steps that will occur during my care/procedure(s), and
    Risks and hazards involved in the care/procedure(s).
- · I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuina.

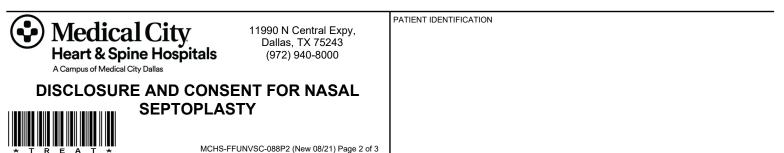
#### Patient/Other Legally Authorized Representative (signature required):

Signature

If Legally Authorized Representative, list relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_ Time:

AM/PM



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Witness:

Print Name	Signature			
Address (Street or P.O. Box)			_	
City, State, Zip Code			_	
Second Witness if Telephone Consent:				
Print Name	Signature _			
Language Services Used     □Yes   □No	Language Provider Conf	firmation Number: _		
<b>Physician Attestation</b> I have explained the Risks, Hazards and Benefits this consent form to the patient or the person auth explaining the Risks/Hazards/Benefits are require and/or surgical procedure, those have been provid	norized to give informed co d to be provided to the pat	onsent prior to their co	nsent. İf written mate	erials
Physician Signature:	Date:	Time:	AM/PM	
Consent and Disclosure Form Adopted from the Texas Admini	strative Code Figure: 25 TAC 86	01 4(a)(1)		

Texas Administrative Code Figure. 25 TAC 9001.4(a)(1).

