WOUND CARE and HYPERBARICS

Consent for Serial Conservative Sharp Debridements

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. The Texas Medical Disclosure Panel Law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Texas Medical Disclosure Panel, (4) reasonable therapeutic alternatives and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures so that you can decide whether to undergo the procedure. In keeping with the Texas Law of Informed Consent, we wish to inform you as completely as possible.

Please read this form carefully and feel free to ask questions.

Patient Name: _____

Treatment/Procedure:
To promote wound healing and decrease the risk for infection of the wound(s), the recommended procedure may include: Serial Conservative Exisional Wound Debridements (repeated procedures involving removal of dead tissue from wound(s) with a sharp instrument), Serial Conservative Non-Exisional Wound Debridements, Incision and Drainage (I&D), and/or other _____
_____
_____

Patient Condition:
Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment or other therapy described above is indicated and recommended: (1) for an open wound or wound/incision requiring attention to aid in healing, (2) other: _____
_____
_____

Risks of Treatment/Procedure:
The risks associated with the medical treatment or therapy described above, as required by the Texas Medical Disclosure Panel Law are: (1) Infection of the wound, (2) infection in the blood, (3) mild to profuse bleeding, (4) disfiguring scars, (5) the loss, or loss of function, of any organ or limb, (6) pain, (7) death, (8) other _____
_____
_____
_____

Reasonable therapeutic alternatives and the risks associated with such alternatives are: (1) Chemical Debridement – results in slower healing and increased risk of infection. (2) other _____
_____
_____

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Patient Notice:

(1) All information given to me and, in particular, all estimates made to the likelihood of occurrence of risk, of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my clinical provider. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.

(2) Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(3) I have had the opportunity to disclose to and discuss with the clinical provider all information, risks, or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me. I have had an opportunity to ask, and have asked, any question concerning the information in this document and any proposed treatment. My questions have been answered in a satisfactory manner.

Consent: ***I hereby authorize and direct the designated authorized clinical provider to administer or perform the medical treatment or surgical procedure described in this document, including any additional procedures or services as they may deem necessary or reasonable, including the administration of a regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure. And I hereby consent thereto.***

I have read and understood all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the proposed medical procedure or surgical procedure described in the document, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Patient/Authorized Designee _____

Date _____

If consent is signed by someone other than the patient, state the reason why:

_____

_____

Clinical Provider:

I hereby certify that I have provided and explained the information set forth herein, including any attachments, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Clinical Provider_____

Date _____