Good Shepherd Medical Center / Marshall, Texas

Orthopaedic History and Physical

Patient Name: Age/Race/Sex: Weight:

Chief Complaint: PICK ONE FROM DROP DOWN LIST

Past Medical History:

Current Medications:

Anticoagulants? : NONE Diabetic? : NO Gout? : NO Hypertension? : NO

Mi? : NO Stroke? : NO Seizures?: NO Gyn History: N/A

Allergies:

PHYSICAL FINDINGS [VITAL SIGNS PER NURSES' NOTES ON ADMIT]

General: WELL DEVELOPED, WELL NOURISHED, NO APPARENT DISTRESS

HEENT: WNL FOR AGE Chest/ Cardiac: WNL FOR AGE

Abdomen: WNL FOR AGE

Extremities: PICK ONE FROM DROP DOWN LIST

Indication for Surgery: PAIN, INTERFERENCE WITH ADL

[also, failure of conservative or non-operative treatment]

Diagnosis: PICK FROM DROP DOWN LIST

Plan: PICK FROM DROP DOWN LIST

_____ Date/Time:

PICK FROM DROP DOWN LIST Patient Name:

Good Shepherd Medical Center / Marshall, Texas

Orthopaedic Discharge Summary

Patient Name:

Findings: PICK FROM DROP DOWN LIST

Treatment: PICK FROM DROP DOWN LIST

Condition on Discharge: Good

Discharge Medication: Lorcet Plus Lortab Vicodin ES Keflex Bactrim

Activity:

Office Appointment in 1 Week

Final Diagnosis: PICK FROM DROP DOWN LIST

_____ Date/Time:

PICK FROM DROP DOWN LIST

Patient Name :

Good Shepherd Medical Center / Marshall, Texas

Orthopaedic Admit Orders

Patient Name: Admit Date:

Diagnosis: PICK FROM DROP DOWN LIST

Allergies:

Admit as:

Lab studies:

Serum pregnancy test? :

P.T.:

Diet:

IV:

Antibiotics:

Routine Op Site Shave and Prep – Do Not Shave nor Prep for Fracture Cases

Pre-Op Med by Anesthesia Provider

_____ Date/Time:

_____ Date /Time:

Nurse Signature

Patient Name:

Disclosure and Consent for Medical and Surgical Procedures - Orthopaedics
Good Shepherd Medical Center / Marshall ---Marshall, Texas

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 to 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 to the procedure.

I/We voluntarily request Dr. D. Duncan / Dr. D. Waldman / Dr. A. Strahan as my physician[s] , 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/We understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I/we voluntarily consent and authorize these **procedures**:

in **lay terms**] :

I/We understand that my physician may discover other or different conditions which 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 or cure.
I/We understand that photographs and videos may be taken of the operation and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities.

I/We DO DO NOT consent to the taking of photographs and videos.

I/We DO DO NOT consent to observation of the operation by authorized personnel.

I/We have been given an opportunity to ask questions about my condition, alternative forms or anesthesia and treatment, risks of non-treatment, the procedures 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 that this form has been fully explained to me, that I/We have read it or had it read to me, that the blank spaces have been filled in, and that I/We understand its contents.

I authorize the hospital pathologist to use discretion in the disposal of any severed tissue or member except: none.

Patient is a minor or unable to sign because: _____

_____

Signature of Patient or Legally Responsible Person **Relationship**

811 S. Washington, Marshall, TX 75670

_____

Signature of Witness **Address** **Date and Time**

I have counseled this patient as to the nature of the proposed procedure(s), attended risks, benefits, and alternatives involved, and expected results, as described above.

Patient Name:

_____

Signature of Counseling Physician **Revised 2/12** **(VALID FOR SEVEN [7] DAYS AFTER SIGNING)**

Patient Name: _____

Disclosure and Consent for Medical and Surgical Procedures - Orthopaedics
Good Shepherd Medical Center - Marshall : Marshall, Texas

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/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 realize that the following risks and hazards may occur in connection with this particular procedure:

C= COMMON, U= UNCOMMON, V=VERY UNCOMMON

C_____PAIN AND/OR DISCOMFORT
C_____NEED FOR REMOVAL/REVISION OF METALLIC OR OTHER IMPLANT
C_____DISFIGUREMENT, INCLUDING DISFIGURING SCARS

U_____NUMBNESS
U_____LIMITATION OF JOINT MOTION / STIFFNESS
U_____AMPUTATION
U_____FAILURE TO ACHIEVE GOALS OF PROCEDURE
U_____OTHER THERAPY MAY BE FOUND NECESSARY
U_____BLOOD TRANSFUSION RISKS - FEVER, TRANSFUSION REACTION, KIDNEY FAILURE, ANEMIA, HEART FAILURE, HEPATITIS, AIDS, OTHER INFECTIONS
U_____LOSS OR LOSS OF FUNCTION OF AN ARM OR LEG
U_____INFECTION
U_____PARALYSIS / FOOT DROP
U_____WEAKNESS
U_____RECURRENCE OR PERSISTENCE OF ORIGINAL PROBLEM
U_____DEFORMITY/SHORTENING OF LIMB

V_____IMPAIRED MUSCLE FUNCTION
V_____ARTHRITIS OR JOINT DEGENERATION
V_____RISK TO ALL MAJOR SYSTEMS OF INVOLVED LIMB
V_____BLOOD VESSEL AND/OR NERVE INJURY
V_____FAILURE TO HEAL
V_____DEATH
V_____FAT ESCAPING FROM BONE TO DAMAGE VITAL ORGAN
V_____BRAIN DAMAGE
V_____LOSS OR LOSS OF FUNCTION OF THE OPERATED ORGANS
V_____PARALYSIS FROM THE NECK DOWN (QUADRIPLEGIA OR PARAPLEGIA)
V_____PARALYSIS FROM THE WAIST DOWN (PARAPLEGIA)

Patient is a minor or unable to sign because: _____

_____ _____
Signature of Patient or Legally Responsible Person **Relationship**

811 S. Washington, Marshall, TX 75670

_____
Signature of Witness **Address** **Date and Time**

I have counseled this patient as to the nature of the proposed procedure(s), attended risks, benefits, and alternatives involved, and expected results, as described above.

_____
Signature of Counseling Physician **Revised 2/12** **(VALID FOR SEVEN [7] DAYS AFTER SIGNING)**

Patient Name : _____

GOOD SHEPHERD MEDICAL CENTER MARSHALL

Disclosure and Consent for Anesthesia Procedures
Good Shepherd Medical Center - Marshall : Marshall, Texas

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 to the procedure.

I/We understand that anesthesia involves additional risks and hazards but I/We request the use of anesthetics for 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 reaction, paralysis, brain damage, or even death.

I /We understand 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; permanant organ damage; memory dysfunction / loss. I/We understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain, persistent back pain, bleeding / epidural hematoma, infection, potential to convert to general anesthesia if block fails or procedure outlasts the block, brain damage, nerve damage. I/We understand that Monitored Anesthesia Care [MAC] may result in permanent organ damage, memory dysfunction, memory loss. I/We understand that Conscious Sedation may have to be converted to general anesthesia if sedation is not adequate.

Patient is a minor or unable to sign because: _____

_____ _____

Signature of Patient or Legally Responsible Person **Relationship**

811 South Washington Marshall, TX 75670

_____

Signature of Witness **Address** **Date and Time**

This permit is obtained as a courtesy to the anesthesia service. Marshall Anesthesia Services provides anesthesia services at Good Shepherd Medical Center - Marshall, and as such is responsible for pre-operative, intra-operative, and post-operative management of anesthesia and any and all related situations or problems arising thereof. The operating surgeon's only responsibility involves the injection of local anesthetic medications in, around, or near the operative field.

_____

Signature of Operating Surgeon **Revised 2/12** **(VALID FOR SEVEN [7] DAYS AFTER SIGNING)**

GOOD SHEPHERD MEDICAL CENTER MARSHALL

Patient Name: _____

CONSENT OR REFUSAL FOR BLOOD OR BLOOD PRODUCTS
GOOD SHEPHERD MEDICAL CENTER / MARSHALL - MARSHALL, TEXAS

I have been advised that transfusion of blood and/or blood components is a necessary or possible part of medical and / or surgical care.

I *CONSENT* TO RECEIVE BLOOD AND/OR BLOOD COMPONENTS

There are risks involved in transfusion and these risks exist despite the fact that the blood and/or blood products have been carefully tested. Among the risks are transfusion reaction [such as kidney failure or anemia], and the possibility of infection with acquired immune dificiency syndrome [AIDS], hepatitis, and any other blood-borne diseases. Also, there is a risk of unexpected blood reactions, such as allergic reactions, fever, chills, rash, or chest pain.
The benefits of receiving blood or blood components are, but not limited to : replenish blood volume and/or blood clotting factors.
The alternatives to receiving blood and blood components have been discussed with me. Depending on my medical condition, the following alternatives may be available for use: autologous blood donation, intra- and post-operative blood cell saver techniques, transfusion of non-blood volume expanders such as crystalloid volume expanders [hypertonic saline, normal saline, lactated Ringers'].
I further acknowledge that I have fully and completely read this document and I understand and comprehend its meaning and that all appropriate blanks have been filled in prior to my signing. This consent is valid until I am discharged from the hospital for this admission. If blood or blood products are given to me as an outpatient procedure, this consent is valid for multiple transfusion episode[s]. I may revoke my consent at any time by informing my attending physician of my wishes.

_____ _____
date / time **signature of patient or legally authorized representative**

_____ _____
signature of physician **signature of witness**

I *REFUSE* TO RECEIVE BLOOD AND/OR BLOOD COMPONENTS

I hereby request and direct that no blood nor blood derivatives be administered to me. **THE RISKS ASSOCIATED WITH REFUSAL HAVE BEEN FULLY EXPLAINED AND ARE FULLY UNDERSTOOD.** The risk of not receiving blood or blood components are, but are not limited to: brain damage, decreased oxygen carrying capacity to major organs and tissue, prolonged bleeding, and/or death.
I hereby release the hospital, its agents and employees, together with all physicians in any way connected, from liability for respecting and following my expressed wishes and direction.
I further acknowledge that I have fully and completely read this document and I understand and comprehend its meaning, and that all appropriate blanks have been filled in prior to my signing. I may revoke this refusal at any time by informing my attending physician of my wishes.

_____ _____
date / time **signature of patient or legally authorized representative**

_____ _____
signature of physician **signature of witness**

Revised 2/12 **(VALID FOR SEVEN [7] DAYS AFTER SIGNING)**

GOOD SHEPHERD MEDICAL CENTER MARSHALL

Patient Name: _____