Exhibit 7–8
DISCLOSURE AND CONSENT: MEDICAL AND SURGICAL PROCEDURES

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

***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) 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 (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: ______________________________

____

____

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.

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

____

____

____

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the 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. 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 (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

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

DATE: ______________________________ TIME: ______________________________ A.M. / P.M.

____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN

WITNESS:

______________________________ ______________________________
Name

______________________________ ______________________________
Address (Street or P.O. Box)

______________________________ ______________________________
City, State, Zip Code

Courtesy of the Texas Medical Disclosure Panel, Texas Department of Public Health

11/88-4

Exhibit 7–16B
ANESTHETIC CONSENT FORM

Complete or imprint with Addressograph.

Name: ______________________________

Room: ______________________________

Medical Record: ______________________________

Sex: __________ Age: __________ Physician: ______________________________

ANESTHETIC CONSENT FORM

I ______________________ (patient) authorize the monitoring of vital bodily functions and the administration of anesthetics to ________________ (patient or responsible party) under the direction of a staff member of the Department of Anesthesiology of ____________________ (hospital). I have had explained to me and I agree to permit the administration of one or more of the following alternative forms of anesthetics (check all that apply) that may be suitable for the procedure I am about to have:

- ☐ General Anesthetic—including intravenous agents and inhaled gases, which will cause unconsciousness.
- ☐ Regional Anesthetic—including needle injections near major nerves, which will temporarily cause me to lose pain sensations in certain areas of my body.
- ☐ Local Anesthetic—including local anesthetic agents with or without intravenously administered sedatives.

I do not consent to the administration of ____________________ (if no exceptions, place X on line) anesthetic. If my regional or local anesthetic is not satisfactory to me or my surgeon, I consent to the administration of general anesthetics.

I understand that during an operation, unforeseen changes in my condition can occur that would necessitate changes in the care provided to me. In that case, the anesthesiologist will act in my behalf with my safety as the first priority.

I am aware that the practice of anesthesiology is not an exact science and that no guarantees can be made about results of anesthetic administration or anesthesia. Common side effects of anesthesia include nausea and vomiting, headache, backache, sore throat or hoarseness, and soft tissue swelling. In addition, even minor surgery can have major unforeseen anesthetic risks. These risks and complications include, but are not limited to, dreams or recall of intraoperative events; corneal abrasions; damage to the mouth, teeth, or vocal cords; pneumonia; numbness; pain or paralysis; damage to veins, arteries, liver, or kidneys; adverse drug reaction; and, rarely, permanent brain damage, heart attack, stroke, or death. These potential risks apply to me whether I have a general, regional, or local anesthetic.

If I am pregnant, I understand that elective surgery should be postponed until after birth of the infant. Anesthetics cross the placenta and can temporarily anesthetize my infant. Although fetal complications of anesthesia during pregnancy are rare, the risks to my infant include, but are not limited to, birth defects, premature labor, permanent brain damage, and death.

I certify that I have to the best of my ability told the anesthesiologist obtaining consent of all major illnesses I have had , of all past anesthetics I have received and any complications of these anesthetics, of any drug allergies I have, and of all medications I have taken in the past year. Also, I have responded truthfully to any additional questions asked by the anesthesiologist.

The nature and purpose of my anesthetic and anesthesia management have been explained to me. I have had the opportunity to ask questions, and the answers and additional information provided have met with my satisfaction. I retain the right to withdraw this consent at any time before the administration of said anesthetic.

Comments: ______________________________

____

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____

____

Physician: ______________________________

Patient or Responsible Party: ______________________________

Relationship of Responsible Party to Patient: ______________________________

Witness: ______________________________

Date: ______________________________

Source: Barbara J. Youngberg, JD, "Risk Management Issues Associated with Anesthesia," *The Risk Manager's Desk Reference*, 2d ed., Barbara J. Youngberg, ed., Aspen Publishers, Inc., © 1998.

GENERAL CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. **Condition:** Dr. ______________________ has explained to me that the following condition(s) exist in my case:

   ____

   ____

   ____

2. **Proposed Procedure(s):** I understand that the procedure(s) proposed for evaluating and treating my condition is/are: ____

   ____

   ____ Right eye _______ Left eye ________

3. **Risks/Benefits of Proposed Procedure(s):**

   A. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.

   B. I also realize that there are particular risks associated with the procedure(s) proposed for me and that these risks include, but are not limited to, those enumerated in the addendum.

4. **Complications; Unforeseen Conditions; Results:** I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

5. **Acknowledgments:** The available alternatives, some of which include __________, the potential benefits and risks of the proposed procedure(s), and the likely result without such treatment, ___________, have been explained to me. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

6. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the physicians, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted by hospital personnel and other trained persons as well as the presence of observers.

______________________________________	______________________
Patient (or person authorized to sign for patient)	Date
______________________________________	______________________
Witness	Date

[SEE ADDENDUM]

[ADDENDUM TO GENERAL CONSENT FORM]
CORNEAL SURGERY

Complications which could occur weeks, months, or even years later:

1. Poor vision, total loss of vision, or loss of eye
2. Bleeding in eye
3. Loss of corneal clarity
4. Chronic inflammation
5. Infection
6. Temporary or permanent blurring of vision because of retinal swelling
7. Detachment of the retina
8. Glaucoma
9. Double vision

Local complications of anesthesia injections around the eye:

1. Perforation of eyeball
2. Destruction of optic nerve
3. Interference with circulation of retina
4. Possible drooping of eyelid
5. Respiratory depression
6. Hypotension

Additional comments:

______________________________________	______________________
Patient (or person authorized to sign for patient)	Date
______________________________________	______________________
Witness	Date