



Procedure Consent

This form is designed to comply with the requirements of 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 & diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

This disclosure is not to harm you 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. Badam at Vayu Advanced Wound Clinic and Hyperbarics MD, CWSP, UHM as my physician as they deem necessary to treat my condition which has been explained to me in detail.

I understand that the Wound Care procedures are planned for me and authorize these procedures.

I understand that my physician and other health care providers may discover other or different conditions which may require additional or different procedures than those planned. I authorize my physician team at Vayu advanced Wound Clinic and Hyperbarics to perform such other procedures which are advisable in their professional judgement.

I do consent that no guarantee or warranty has been made to me as a result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards with surgical, medical and diagnostic procedures planned to me.

The potential risks, benefits and alternatives have been reasonably discussed with me, including risks, benefits of non-treatment and alternative treatment.

I have had the opportunity to ask about the proposed treatment, procedure, alternative treatment as well as risks of non-treatment and steps that will occur during my treatment procedure.

I realize the common to surgical, medical or diagnostic procedures is the potential for infection, excessive bleeding, blood clots in veins, and lungs, allergic reaction & even death.

I /we have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, 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 certify that this form was explained to me/us that I/we have read in full and I/we understand the contents.

Signature: _____

Patient Name: _____ Date: _____