COOK CHILDREN'S HEALTH CARE SYSTEM
CONSENT FOR TREATMENT

MEDICAL DENTAL AND SURGICAL CONSENT: By signing this form, I am consenting to any exams, X-rays, laboratory procedures, tests, medications, medical treatment, dental treatment, pictures, videos, and other services determined advisable for the patient by the attending doctor or other healthcare providers. Other healthcare providers could include other treating or consulting doctors, dentists, their associates, technical assistants, nurses, and other hospital staff.

This consent applies during the evaluation, diagnosis and treatment of the patient being cared for by Cook Children's Health Care System and its affiliated companies (also known as "CCHCS"). CCHCS companies include: Cook Children's Medical Center ("CCMC"), Cook Children's Physician Network, and Cook Children's Home Health.

I also consent to allow students (such as medical fellows, medical residents, medical students, student nurses and other authorized individuals that are enrolled in professional training programs) and physicians undergoing training to watch or join in the care provided as the treating doctors or dentists find appropriate, and as allowed by CCHCS policy.

I understand that no one can guarantee the results of any healthcare treatment. I agree that any tissue or body parts removed from the patient will be kept and disposed of by CCHCS according to its policies.

DOCTORS DENTISTS AND INDEPENDENT CONTRACTORS: Each patient within CCHCS is under the care of a doctor and/or dentist. Doctors and dentists are not always employees of CCHCS. Some doctors or dentists may be independent contractors. All doctors and dentists assume responsibility for the medical or dental care they provide.

ACCIDENTAL EXPOSURE TO THE HEALTHCARE WORKER: I understand that Texas law states that if any healthcare worker is exposed to a patient's blood or other bodily fluid, then CCHCS may perform test(s) for HIV (the "Human Immunodeficiency Virus") on that patient's blood or bodily fluid. I give consent to test for other diseases too, including hepatitis, syphilis, and others. I understand that these tests are necessary to protect healthcare workers who are caring for CCHCS patients.

PATIENT RIGHTS AND RESPONSIBILITIES: If I or my child is being admitted to CCMC, I will be given written information on the rights and responsibilities of the patient. This information tells me how to file a complaint or grievance if I have a problem with the care the patient receives during the hospital stay.

MONEY AND PERSONAL VALUABLES: CCHCS maintains a locked safe where I can store money and valuables. I understand that CCHCS will not be responsible for lost or damaged money or property unless those things are brought to the CCHCS safe and left there. I will be given a written receipt for them. I understand that I must have the receipt with me to get the things back out of the locked safe.

THE PERSON SIGNING THIS CONSENT FORM CERTIFIES THAT: 1) HE/SHE IS EITHER THE PATIENT, PARENT OF THE PATIENT, OR LEGALLY AUTHORIZED REPRESENTATIVE OF THE PATIENT; 2) HAS READ (OR HAS BEEN READ) THIS FORM AND UNDERSTANDS WHAT IT SAYS; AND 3) AGREES TO THE TERMS OF THIS CONSENT FORM.

Patient's Name Printed: _____ Date of Birth: _____

Patient/Parent/Legal Guardian Signature: _____ Date/Time: _____

Relationship to the Patient: _____

Witness: _____ Date/Time: _____

PRINT OR IMPRINT PATIENT INFORMATION

CADMIT

Cook Children's
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Fort Worth, Texas 76104-2796

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