

Consent Form - Image Guided Pain Management Injection

Washington State Law guarantees that you have both the right and the obligation to make decisions concerning your healthcare. Your physician can provide you with the necessary information and advice. But as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

- 1) I hereby authorize Dr. _____ and/or such associate or assistants as may be selected by said physician to treat the following condition (s) which has been explained to me in professional and lay language below:

Diagnose and treat back pain and/or sciatica (radicular pain) caused by inflammation.

- 2) The procedures planned for treatment of my condition have been explained to me by my physician. I understand them to be:

Epidural injection: Place needle into space outside sac containing spinal cord and nerve roots (epidural space) in back, and inject anti-inflammatory medicine (solution of steroid and numbing medicine). Risks include infection, dural puncture with headache, bleeding, and nerve or spinal cord damage.

- 3) I recognize that during the course of the above procedure, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate additional or different procedures than those above set forth. **I therefore authorize my above named physician, and his assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her, or their professional judgment necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of medical or surgical procedure is commenced.

- 4) **I have been informed that there are significant risks** such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. **I acknowledge that no warranty or guarantee has been made to me as a result or cure.**

I CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I UNDERSTAND ITS CONTENTS.

Important: Have Patient Sign Full or Limited Disclosure Box Below and Signature Line at Bottom of Page.

FULL DISCLOSURE

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment; and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and in alternative forms of treatment, including non-treatment.

Patient/Other Legally Responsible Person Sign as Applicable

LIMITED DISCLOSURE

I certify that my physician has explained to me that I have the right to have clearly described to me the nature and the character of the proposed treatment: the anticipated results of the proposed treatment, the alternative forms of treatment and the recognized serious possible risks, complications, and anticipated benefits involved in the proposed treatment and in alternative forms of treatment, including non-treatment.

I do not choose to have these risks and facts explained to me.

Patient/Other Legally Responsible Person Sign as Applicable

Any sections below which do not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both physician and patient.

5) I consent to the administration of anesthesia by my attending physician, by an anesthesiologist, or a qualified party under the direction of the physician as deemed necessary. I understand that all anesthetics involve risk of complications and serious possible damage to vital organs such as brain, heart, lung, liver, and kidney and that in some cases may result in paralysis, cardiac arrest and/or brain death from known and unknown causes.

6) I consent to the use of transfusions of blood and blood products that are deemed necessary.

7) Any tissues or parts surgically removed may be disposed of by WIS or the physician in accordance with accustomed practices.

Patient or Legally Responsible person signature

Relationship of legally responsible person to patient

Date: _____ Time: _____

Witness: _____



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