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Procedure Consent Form

Patient Name: «LastName», «FirstName» DOB: «DOB» Date: «encDate»

Diagnosis: _____ Procedure:_____

1. In conjunction with the procedure identified above, I understand the following:
   a. **Nature and purpose of procedure:** (Describe in laymen's terms): *Inject local anesthetic and steroid into the _____under fluoroscopy.*
   b. **Material risks of procedure:** DEATH, CARDIAC ARREST, BRAIN DAMAGE, DISFIGURING SCAR, PARAPLEGIA OR QUADRIPLEGIA, PARALYSIS OR PARTIAL PARALYSIS, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, SEVERE LOSS OF BLOOD, ALLERGIC REACTION AND INFECTION. Other risks of procedure are:_____
   _____
   c. **Likelihood of success:** ☐Good ☐fair ☐Poor ☐Unknown because:_____
   _____
   d. **Practical alternatives to procedure:** ☐None ☐Other _____
   _____
   e. **Prognosis if procedure rejected:** ☐Good ☐Fair ☐Poor ☐Unknown because:_____
2. **CONSENT:** The procedure identified above has been explained to me and all my questions have been answered. I acknowledge that no guarantees have been made concerning the outcome of the procedure. I hereby consent to the performance of this procedure by Dr. Navdeep Loomba and/or any assistants selected by this physician/surgeon. I also consent to the administration of anesthesia by a physician from the Department of Anesthesiology of Global Pain Care, and/or any assistance selected by, and acting under the direction and supervision of, this physician.
3. I realize that, during the procedure, the physician/surgeon may become aware of conditions which were not apparent before the start of the procedure. I therefore consent to any additional or different operations or procedures the physician/surgeon considers necessary or appropriate to treat cure or diagnose such conditions.
4. Any tissue, organ, specimen, or member taken or severed in any operation or procedure may be retained, preserved, use foe scientific or teaching purposes, or disposed of by the Clinic in accordance with customary practice for the follow:_____
   _____
5. If acceptable to the physician/surgeon , I authorize observers to be present during the surgery or procedure.(☐Yes ☐No) I further authorize the physician/surgeon , or his/her designee, to photograph/videotape me before, during, or after this surgery or procedure, for purposes related to my care and treatment and/or purposes of medical education. (☐Yes ☐No)

_____ _____
Physician/ surgeon Signature Patient Signature