WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

Consent Procedure

Patient Identification Area

PROCEDURE REQUEST FORM

Planned Procedure/Treatment:

❑ EPIDURAL STEROID INJECTION(S)
❑ INTRAVENOUS SEDATION
❑ FLUOROSCOPY
❑ RADIOGRAPHIC CONTRAST, IF INDICATED
❑ DIAGNOSTIC MEDIAL BRANCH BLOCK(S)
❑ DISKOGRAPHY
❑ SACROILIAC JOINT INJECTION(S)
❑ RADIOFREQUENCY ABLATION(S)
❑ EPIDURALOSCOPY WITH TREATMENT, AS INDICATED
❑ SYMPATHETIC NERVE BLOCK(S)
❑ EPIDURAL BLOOD PATCH
❑ IV MEDICATION INFUSION
❑ SPINAL CORD STIMULATION PERCUTANEOUS TRIAL EPIDURAL LEAD(S) PLACEMENT
❑ SPINAL CORD STIMULATION PERCUTANEOUS EPIDURAL LEAD(S) IMPLANT(S) IPG (BATTERY) IMPLANT
❑ OTHER _____

LOCATION _____

Diagnosis/Reason for Procedure/Treatment: _____

_____

This procedure will be performed by ❑ **DR. JORGENSEN** ❑ **DR. THAPA** ❑ **DR. CURATOLO**
❑ **SHELLEY LANDRY MPA−C** ❑ **JULIA ORSI, NP** ❑ **KELLY HOCHSTETLER, PA−C**
and/or his/her associate(s) and any assistants s/he designates.

I have been informed of the risks, complications, or adverse consequences associated with this procedure including, but not limited to: *infection, bleeding, loss of use of body parts, cardiac arrest, and death.* The above procedure has been fully explained. I have been informed of the benefits of having this procedure and alternative treatments available. I understand that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment. I impose no specific limitations or restrictions on my treatment.

If the administration of local anesthetics, sedatives, and painkillers is deemed necessary in the judgment of the physician performing the procedure, I understand this will produce a general state of sedation during the procedure; and that the potential complications of these medications can include lowering of blood pressure, reduction in breathing and blood oxygen, airway obstruction, and heart rhythm disturbances.

I authorize the physician(s) performing the procedure and the Hospital to preserve any body fluids or tissues removed during the procedure or treatment for scientific or teaching purposes, or to use in the treatment of other patients. I understand that my tissues, fluids or other body parts will not be used for commercial purposes without my written consent. I also authorize the Hospital to dispose of any tissues, body parts or organs removed as a necessary part of my treatment in accordance with acceptable medical practices.

I REQUEST THE ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS IF NECESSARY IN THE JUDGMENT OF THE ANESTHESIOLOGIST OR SURGEON. I understand the potential need for a blood transfusion and available alternatives. I understand that the transfusion of blood is associated with risks that cannot be completely avoided, even by the most careful modern blood banking techniques. These risks include, but are not limited to transmission of infectious disease, particularly hepatitis and acquired immune deficiency syndrome, and the possibility of severe transfusion reactions. These reactions may produce fever, hives, or more serious reactions such as shock and/or kidney shutdown.

I understand that portions of the procedure may be photographed or videotaped to document my treatment and that this will be part of my medical record. Portions of my procedure may also be photographed or videotaped for teaching, research or scientific publication, but these photos and videos will not reveal my identity. If any photo or video for teaching, research or scientific publication might reveal my identity, ***I will be asked to sign an authorization for that purpose.*** My provider has informed me of any observers that may be present during the procedure and I have been offered the opportunity to object.

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. **All blank spaces have been either completed or lined out prior to my signing this document.** I have been informed that I can change my mind and withdraw consent at any time before the procedure or treatment.

_____	_____	_____
Signature of Patient, Parent, Guardian, Health Care Agent, or other Representative of Patient	Relationship (if other than patient)	Date / Time

Statement of Practitioner Obtaining Consent

I certify that I have explained to the patient the risks, benefits, and alternatives of this procedure as well as the probably consequences of receiving no treatment. I have answered all of his/her questions.

_____
Signature of Practitioner