Advanced Imaging Center

CONSENT FOR RADIOLOGY PROCEDURE

Patient Name: _____

INTRODUCTION:
Your physician has requested that you undergo a procedure known as a: _____

This procedure is being performed to further evaluate and/or treat your diagnosis of: _____

We are asking you to read and sign this form so that we can be sure you understand the risks and complications potentially associated with this procedure. Please ask questions about anything on this form that you do not understand.

DESCRIPTION OF PROCEDURE:
This procedure involves the placement of a fine needle through your skin and into a designated location. Some numb ing medicine will be injected in the skin over the site that will be used before the needle is inserted. Medications may also be given to you to make you more comfortable and relaxed. This is known as conscious sedation. Following insertion, the needle will be guided into position with a camera, using either x-rays (fluoroscopy or CT), sound waves (ultrasound) or magnetic signals (MRI). The position of the needle may be confirmed by the injection of x-ray contrast material (x-ray dye) and/or removal of fluid. It may be necessary to make more than one pass of the needle to achieve the proper location. Depending on your condition, a drainage tube may be placed, a tissue sample taken or material injected through the needle. The specific procedure planned for your condition is:

_____

RISKS:
Risks associated with the procedure include pain or discomfort at the needle insertion site, bleeding at the site, injury to a blood vessel, organ puncture, infection which may result in an infection of the blood stream, the development of a blood clot (embolization), and stroke. Risks associated with the x-ray contrast material include an allergic reaction and reduced kidney function. The medications used for the conscious sedation are associated with the risks of aspiration (inhaling food or liquid into your lungs) or respiratory depression. In addition to these potential risks associated with the procedure, the x-ray contrast material, and the conscious sedation medications, there may be other unpredictable risks including death.

ALTERNATIVES:
There may be other procedures that can be performed to further evaluate and/or treat your condition. If you are unsure about having this procedure performed, please discuss these other alternatives with your physician.

AGREEMENT:
The information on this form was explained to me by _____. I understand the information and I have had the opportunity to ask my physician any other questions I might have about the procedure, the reasons it is being performed, the associated risks, and the alternatives to the procedure. I have voluntarily agree to have the procedure performed and accept the risks. I agree that if deemed necessary that submission of tissues may be made to a laboratory for diagnostic analysis. In addition, I am aware that no guarantee or assurance has been made as to the results of this procedure.

Patient Signature: _____ Date and Time: _____

Physician Signature: _____ Date and Time: _____

Witness Signature:_____ Date and Time: _____

_____

The following to be used if the patient is a minor, unconscious, or otherwise lacking decision making capacity:

I, _____, the _____ of _____ hereby give consent.

Relative, Surrogate, or Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness to Telephone Consent Signature: _____ Date: _____