South Sound Radiologists, Inc., P.S.

INFORMED CONSENT
MYELOGRAM

Washington State law guarantees that you have both the right and obligation to make decisions concerning your healthcare. Your clinician (physician or healthcare provider) 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 clinician.

Patient:_____ **Patient** #:_____

I hereby authorize Dr._____and/or such associates or assistants as may be selected by the aforementioned physician to perform a **MYELOGRAM**.

PROCEDURE: Injection of contrast (x-ray dye) through a needle placed into the spinal canal of the back or neck using x-ray guidance. The x-ray table may be tilted up and down during the procedure. A CT scan may be performed following this procedure.

RISKS: I understand that all procedures carry some risk. We (your referring clinician and radiologist) would not recommend this procedure unless we believed the advantages far outweighed the disadvantages. However, you must understand and accept the potential risks. The potential risks include, but are not limited to: pain, bleeding, infection, headache, nausea, vomiting, back pain, muscle spasm, and allergic/adverse reaction to injected medications. Rare potential risks included nerve, spinal cord or vessel injury, seizure, disability, bowel/bladder dysfunction, dizziness, hallucination, blindness, meningitis, brain herniation and even, death. There is a chance that the needle will not be able to be placed successfully into the desired spinal canal space.

BENEFITS: Diagnosis of pain or disability.

ALTERNATIVES TO PROCEDURE: Spinal MRI, no procedure, or appropriate medical and/or surgical management.

You always have the right to refuse any procedure at any time. It is your responsibility to inform us if you do not want the procedure or wish to stop during the procedure after it has started. It is also your responsibility to inform us of any prior adverse outcome or reaction to a similar study or x-ray dye.

I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I therefore, authorize the above-named physician, and his or her assistants or designees, to perform such procedures as in his or her professional judgment are 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 the medical procedure is commenced.

I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and I understand its contents.

_____ _____

Patient/Other Legally Responsible Person Signature Date Time

Post procedure care:

1. Drink plenty of water following the procedure.
2. Take it easy the rest of the day.
3. Tylenol as needed for mild headache.
4. If headache persists when upright, but feels better while lying down, call SSR.

_____

Radiologist Signature

_____

Witness

05/2011