



ST. VINCENT'S MELBOURNE
CT/FLUOROSCOPY GUIDED LUMBAR PUNCTURE
PROCEDURE CONSENT FORM

UR No.:	_____
Surname:	_____
Given Name:	_____
D.O.B.:	_____
Please fill in if no Patient Label available	

Your treating doctor has asked us to perform a:

Left Right Not Applicable *(hospital to circle, as appropriate)*

(hospital to insert procedure name)

Your treating doctor has decided that the benefits you might get from this procedure are far more important than the risks.

Although very unlikely, the possible risks and complications include:

- Bleeding
- Infection
- Cerebrospinal fluid leak
- Weakness or numbness
- Headache
- Allergy
- Insufficient sample

Please complete this section and **bring this form in with you** on the day of your procedure:

I understand the proposed procedure and acknowledge the risks of the procedure.
 I understand that I will have the opportunity to discuss and clarify any concerns or questions with the doctor on the day of the procedure.

Further questions to complete: please notify one of our nurses by phone on **9231 3654** if you answer "Yes" or "Unsure" to any of these questions:

Patient to complete	Are you on blood thinning medication?	No	Yes	Last dose	_____
	Any allergies to medications?	No	Yes	Details	_____
	Any allergies to dressings?	No	Yes	Details	_____
	Do you have a history of diabetes on medication?	No	Yes	Details	_____
	Are you pregnant?	No	Yes	Unsure	

Patient signature: _____ Patient PRINT name: _____ Date: _____

Hospital doctor to sign on the day of the procedure (below)
 Treating doctor signature: _____ Treating doctor PRINT name: _____ Date of procedure: _____