ST VINCENT'S HOSPITAL MELBOURNE

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CT GUIDED CERVICAL NERVE ROOT INJECTION 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
- Variable or incomplete pain relief
- Weakness or numbness
- Skin changes
- Temporary worsening of symptoms
- Allergy

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.

Patient to complete

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:

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: