Perez Neurology

2695 S LeJeune Road Suite 200

Coral Gables, FL 33134

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PROCEDURE(S):			
Consent for L ck	ower Cervic	al Muscular Injections and/or Greater Occipit	a
cedures on me	, and I voluntarily		/o
Right	Left	Bilateral	
	consent for L	consent for Lower Cervicesk consecution in the consecution is consecuted by the consecution is consecuted by the consecution in the consecution is consecuted by the consecution in the consecution is consecuted by the consecution in the consecution is consecuted by the con	consent for Lower Cervical Muscular Injections and/or Greater Occipitek

oUsing a local anesthetic plus steroid

oUsing a local anesthetic

I realize that surgical, medical and/or diagnostic procedures carry risks which may include infection, bleeding, unacceptable cosmetic results, allergic reactions and cardiac arrest, respiratory distress or death. I also realize that there are risks associated with this particular procedure including, but not limited to: infection or bleeding at the injection site, increase in pain, new pain or failure to relieve pain, ataxia (which is a lack of muscle coordination which may affect speech, eye movements, swallowing, walking and other voluntary movements), nystagmus (uncontrolled movements of the eyes), blurred vision, double vision and blindness. Side effects from the steroid may include redness, flushing around the face and an allergic reaction to the medication injected.

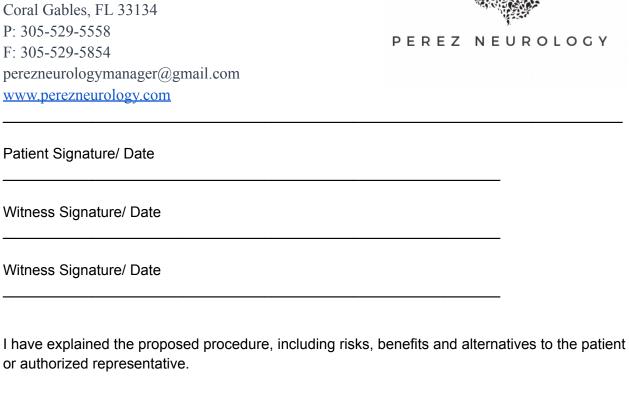
I understand that during the course of the surgical, medical and/or diagnostic procedure my physician may discover other or different conditions that require additional or different procedures than those currently planned. I authorize my physician and other healthcare providers to perform such other procedures which are advisable in their professional judgment. My physician discussed with me whether other well qualified medical practitioners including, but not limited to, residents will perform important tasks of surgery.

I acknowledge that the following have been discussed with me and that I have an understanding of my current medical condition, the proposed procedure, including risks and benefits, probability of success, alternative treatments and their associated risks,

as well as the risks of not having the procedure. I have had the opportunity to ask questions which have been answered to my satisfaction and agree to proceed.

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_____/___Signature of Practitioner Practitioner # (or badge #) Date Time

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