Perez Neurology
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PROCEDURE(S):

Informed Consent for Lower Cervical Muscular Injections and/or Greater Occipital Nerve Block

I authorize Dr. _____, to perform the following surgical, medical and/or diagnostic procedures on me, and I voluntarily consent to and authorize these procedures, for the treatment of my current medical condition:

Patient's: **Right** **Left** **Bilateral**

o**Using a local anesthetic**

o**Using a local anesthetic plus steroid**

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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Patient Signature/ Date

_____

Witness Signature/ Date

_____

Witness Signature/ Date

_____

I have explained the proposed procedure, including risks, benefits and alternatives to the patient or authorized representative.

_____ _____

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

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