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## Outpatient Consent for Procedure

I, hereby authorize Athens Spine Center physicians, associates and assistants, to perform the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Epidural Steroid Injection | <input type="checkbox"/> Transforaminal Steroid Injection | <input type="checkbox"/> Facet Joint Injection |
| <input type="checkbox"/> SI Joint Injection         | <input type="checkbox"/> Trigger Point Injection          | <input type="checkbox"/> Medial Branch Block   |
| <input type="checkbox"/> Occipital Nerve Block      | <input type="checkbox"/> Discography                      | <input type="checkbox"/> Radiofrequency        |
| <input type="checkbox"/> Other: _____               |   |  |

on the following site:

- Lumbar     Sacral     Cervical     Thoracic     Other: \_\_\_\_\_

The potential benefits of procedure, alternative treatments, and consequences of no treatment have been explained to me. I understand that any procedure involves some serious and possibly fatal risks and side effects. The risks and side effects may include, but are not limited to: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, damage to nearby organs, need for re-operation and pneumonia. **I understand that this procedure may not be successful in alleviating my pain and/or may require more than one injection.** Some other significant additional risks of the procedure may include:

\_\_\_\_\_

\_\_\_\_\_

If a different, unsuspected condition is discovered during the procedure, I authorize the performance of such other procedures as deemed medically necessary, except:

\_\_\_\_\_

\_\_\_\_\_

**NOTE: IF NO EXCEPTIONS, WRITE "NOT APPLICABLE"**

I have not taken any anticoagulant medication for \_\_\_\_\_ days prior to this procedure.

I [ ] do [ ] do not object to medical students, trainees or anyone approved by an Athens Spine Center physician (other than ASC staff) present during my procedure for **observation only**.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient / Responsible Party

I have explained the contents of this document to the patient and have answered the patient's questions. To the best of my knowledge, the patient has been adequately informed. The patient has consented.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Individual Obtaining Consent

Final Verification/timeout immediately prior to incision/procedure has been conducted by the surgeon/proceduralist, anesthesia provider, and members of the surgical/procedural team as appropriate to their involvement in the procedure. The patient's identity, procedure, and when applicable the: side/site, patient position, availability of implants and any special equipment or special requirements was verbally confirmed prior to the procedure.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

<b>FOR INTERNAL USE ONLY</b>			
<input type="checkbox"/> Consent Approval	<input type="checkbox"/> Driver	<input type="checkbox"/> NPO Since:	Preg: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> ANTICOAGULANTS	<input type="checkbox"/> D/C #	days prior (per patient)	Pacemaker/Defib: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> NIDDM	<input type="checkbox"/> IDDM		PT/INR WNL: