Infection, bleeding, damage to surrounding structures, paralysis, death

To diagnose the cause of the headache, evaluate for bleed or infection

Missing diagnosis, worsening symptoms

Lumbar Puncture

under the direction of Dr. [name] or designee with the assistance and participation of fellows, residents, physician extenders, and/or students under the supervision of attending physicians/doctors.

To diagnose the cause of the headache, evaluate for bleed or infection

Infection, bleeding, damage to surrounding structures, paralysis, death

Missing diagnosis, worsening symptoms

No lumbar puncture

I understand that for this procedure, the act of delivering analgesia/anesthesia has benefits of relief and protection from pain, but carries no guarantees. Common side effects include nausea and vomiting, headache, sore throat or hoarseness and soft tissue swelling.

Many types of risks and complications associated with anesthesia include, but are not limited to: dreams or recall of intraoperative events, incomplete analgesia, damage to the mouth, teeth or vocal cords, pneumonia, loss of sensation, loss of limb function, paralysis, damage to veins or arteries, adverse drug reaction and in rare instances, permanent brain damage, abnormal heart beats, heart attack, stroke or death.

I understand that if I am taking medications, they may cause complications with anesthesia or surgery. I understand that it is in my best interest to inform my doctors about the nature of any medications that I am taking including but not limited to aspirin, herbal medicines, cold remedies, narcotics, PCP, marijuana, and cocaine.
CONSENT FOR SURGERY / DIAGNOSTIC AND OTHER PROCEDURES AND TREATMENT

13. VENDOR(s) in OPERATING ROOM:
Vendor(s) or Vendor’s Representative(s) in the Operating Room: I have been informed that vendor(s) or vendor’s representative(s) may be present in the operating room to provide technical or logistical support to my surgeon(s) and/or the operating room staff and authorize such. At no time will any vendor(s) or vendor’s representative(s) provide any direct patient care to me.

14. PATIENT’S CONSENT:
I certify that I have read and fully understand this consent form, that I understand the reason and purpose of the operation or procedure, its risks, benefits and alternatives, and possible complications as explained to me by:

Physician or Clinical Practitioner (Print Name): ________________________________

I certify that all explanations referred to above were made, and that all blanks and statements requiring insertion or completion were filled in before I signed the consent. I acknowledge and understand that no guarantee or assurance has been made as to the results of the procedure.

SIGNATURE OF PATIENT __________________________ DATE / TIME __________________________

I certify that I have witnessed the person whose signature appears on this form signing this Consent for Surgery/Diagnostic and Other Procedures and Treatments.

SIGNATURE OF WITNESS __________________________ DATE / TIME __________________________

If patient is unable to sign, signature of legally responsible person __________________________ Relationship to Patient __________________________

Reason why patient is unable to sign consent: __________________________

15. PRACTITIONER CERTIFICATION:
The procedure or operation stated on this form, including the possible risks, benefits, complications, alternative treatments (including non-treatment) and anticipated results, was explained by me to the patient or his/her representative.

SIGNATURE OF PHYSICIAN OR CLINICAL PRACTITIONER __________________________ DATE / TIME __________________________

16. VERBAL INFORMED CONSENT by TELEPHONE:

NAME OF PERSON GIVING TELEPHONE Consent __________________________ DATE / TIME __________________________

RELATIONSHIP TO PATIENT __________________________

TELEPHONE AND ADDRESS OF PERSON GIVING TELEPHONE Consent: __________________________

PRINT NAME OF PHYSICIAN OR CLINICAL PRACTITIONER WHO OBTAINED CONSENT __________________________ SIGNATURE OF PHYSICIAN OR CLINICAL PRACTITIONER WHO OBTAINED CONSENT __________________________

PRINT NAME OF WITNESS TO TELEPHONE Consent __________________________ SIGNATURE OF WITNESS TO TELEPHONE Consent __________________________

INTERPRETER: (If Required)

PRINTED NAME OF INTERPRETER __________________________ DATE / TIME __________________________

SIGNATURE OF INTERPRETER __________________________