

South Sound Radiologists, Inc., P.S.

INFORMED CONSENT

ARTHROGRAM / JOINT INJECTION / JOINT ASPIRATION

Washington State law guarantees that you have both the right and obligation to make decisions concerning your healthcare. Your clinician (physician or healthcare provider) can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your clinician.

Patient: _____ **Patient #:** _____

I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by physician to perform an ARTHROGRAM / JOINT INJECTION / JOINT ASPIRATION.

PROCEDURE: Placement of needle into the joint (shoulder, wrist, hip, knee, elbow, or ankle) using x-ray or ultrasound guidance with possible injection of contrast (x-ray dye), local anesthetic or steroid and/or the removal of a small sample of joint fluid.

RISKS: I understand all procedures carry some risk. We (your referring clinician and radiologist) would not recommend this procedure unless we believed the advantages far outweighed the disadvantages. However, you must understand and accept the potential risks. The potential risks include, but are not limited to: pain, bleeding, infection, joint stiffness, allergic/adverse reaction to injected medications, or temporary anesthesia (numbness or weakness). Rare potential risks include nerve, vessel or joint injury, weakness, numbness, disability, seizure, arrhythmia, and even, death. There is a chance that the needle will not be able to be placed successfully into the desired joint space.

BENEFITS: Diagnosis of the cause of pain or disability or diagnosis of infection.

ALTERNATIVES TO PROCEDURE: MRI, no procedure, or appropriate medical and/or surgical management.

YOU ALWAYS HAVE THE RIGHT TO REFUSE ANY PROCEDURE AT ANY TIME. IT IS YOUR RESPONSIBILITY TO INFORM US IF YOU DO NOT WANT THE PROCEDURE OR WISH TO STOP DURING THE PROCEDURE AFTER IT HAS STARTED. IT IS ALSO YOUR RESPONSIBILITY TO INFORM US OF ANY PRIOR ADVERSE OUTCOME OR REACTION TO A SIMILAR STUDY OR X-RAY DYE.

I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I, therefore, authorize the above-named physician, and his or his assistants or designees, to perform such procedures as are in the professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of the medical procedure is commenced.

I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and that I understand its contents.

Patient/Other Legally Responsible Person Signature

Date

Time

Witness

Revised: 11/02/02