PNP Premier Neurology & Pain Specialists

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Wyandotte MI 48192

Consent for Surgery, Anesthesia, Invasive and/or Diagnostic procedures

The physician (s) and practitioner (s) are:

_____

The procedure is(are):

_____

_____

I have discussed the proposed treatment and/or diagnostic procedure with the patient or patient's representative. I have informed the patient regarding the risks, benefits, side effects and expected outcomes and likelihood of achieving the goals for the procedure including potential alternatives, and the possible results of not receiving treatment.

_____ _____ _____
Physician/NP/PA signature Date Time

Patient Acknowledgment and Consent

1. I know that one cannot promise that I and can be cured.
2. I know that I can be hospitalized or become sicker as a result of this procedure.
3. I know that any of the spine procedures (cervical, thoracic, lumbar, peripheral nerve blocks) can potentially result in worsened pain, infection, bleeding, spinal cord injury, paralysis, stroke, seizures, cardiac or respiratory arrest, confusion or even death. There also maybe other risks associated with these procedures that are not listed here.
4. I know the electromyography/Nerve conduction tests (EMG/and electroencephalograms (EEG) are diagnostic tests. I also know that the EMG test requires the use of needle and that can cause me pain.

By signing below, I agree to:

1. That I have read all of the above and was afforded all the necessary time prior to the procedure to ask questions. All of my questions have been addressed by the physician at Premier Neurology and Pain Specialists.
2. The planned treatment, diagnostic test, operation has been explained to me in terms that were clear and I have established full understanding prior to proceeding with the treatment or diagnostic test.
3. Any medicine that may be given to me to make me sleepy or block pain has been told to me so that I understand.
4. I have all the information that I need. I understand that information regarding me maybe disclosed or reported.
5. I have been able to ask questions that I have about the: treatment, test or operation, risks, benefits and potential side effects, other treatment or diagnostic options and likely results.
6. I agree and give my permission for the staff at Premier Pain and Neurology Specialists to proceed with the procedure.

_____ _____ _____
Patient or patient representative signature Date Time

_____ Date_____ Time_____
Witness Signature (witness only witnesses the signature and has to be a person other than the operator/physician)