

**PHYSICIANS' SPINE CENTER
INFORMED CONSENT FOR MYELOGRAM**

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENT

PATIENT'S NAME: _____

DATE: _____

The following has been explained to me and I understand that:

- 1) The REASON THIS PROCEDURE IS BEING PERFORMED is: _____
- 2) The NATURE OF THE PROCEDURE is: insertion of a needle into the spinal canal, injection of iodine contrast.
- 3) The PURPOSE OF THE PROCEDURE is: to detect the cause of your pain.
- 4) MATERIAL RISKS OF THE PROCEDURE include: infection. In addition, there may be other possible risks such as pain, weakness and numbness of the arms and legs, headache and worsening of your presenting symptoms.
- 5) The administration of a non-ionic contrast material may be necessary to use to obtain additional diagnostic information. Usually, contrast material is quite safe. However, any injection carries some risk of harm. Occasionally, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly (1:1,000), a serious reaction occurs. Very rarely (1-2:100,000) death has occurred related to contrast administration.
- 6) The LIKELIHOOD OF SUCCESS OF THE ABOVE PROCEDURE is: GOOD.
- 7) PRACTICAL ALTERNATIVES TO THIS PROCEDURE include: no treatment, oral medication, and/or bed rest.
- 8) I understand that the physician, medical personnel, and other assistants will rely on statements about and/or from myself, my medical history, and other information in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure which has been explained.

Please check any of the following characteristics you may have and alert the staff:

- A history of adverse reaction to contrast material with the exception of heat/flushing sensation or a single nausea/vomiting episode.
 - A history of asthma or allergy.
 - Significant heart disorder including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
 - Any drug allergy.
 - Diabetic
 - Pregnancy.
 - Taking any blood thinners.
- 9) I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure.
 - 10) I consent to diagnostic studies, tests, local and/or general anesthesia, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis or procedures described herein as may be deemed advisable.
 - 11) I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.
 - 12) Additional materials used, if any, for this procedure include: _____
 - 13) I voluntarily allow Dr. _____ OR an associate and all medical personnel under the direct supervision and control of such physician along with all other personnel who my otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.
 - 14) I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such procedures as they deem necessary or appropriate.
 - 15) If I choose not to have the above procedure, my prognosis (future medical condition) is: UNKNOWN.
 - 16) I consent to the release of all records pertaining to my treatment to other physicians or health professionals involved in my case.
 - 17) By signing this form I acknowledge that I have read or have had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions, that my questions have been answered satisfactorily, and that I knowingly and voluntarily give my complete unfettered consent to the procedures described herein. All blanks or statements requiring completion were filled in, and all statements I do not approve of were stricken before I signed this form. I have received additional information including, but no limited to, the materials listed above related to the procedures described herein, and I authorize you to give me reasonable and proper care by today's standards.

Signature of person giving consent: _____ Date: _____

Relationship to patient, if not patient: _____ Time: _____

Patient unable to sign because: _____ Witness: _____

MYELOGRAPHY- PATIENT INFORMATION SHEET

Your physician has scheduled you for a myelogram. It involves the insertion of a needle into your spinal canal followed by an injection of a contrast agent containing iodine. This procedure may help determine the cause of the problem you may be having in your spine.

Even though extremely rare, the use of this contrast material as well as the procedure itself does carry some risks and side effects. The risks include infection, persistent headache, and an allergic reaction. There is also a risk of bleeding if you are on medications to thin your blood. The side effects include irritation to the nerves in your brain which may result in headache or seizure.

There are alternative methods of imaging various parts of the body, each with its unique advantages and disadvantages. Your physician is aware of these diagnostic alternatives and has requested the myelogram as the optimal one for your circumstances.

The radiologist and technologist will answer any questions you may have prior to beginning this procedure.

PLEASE SIGN HERE TO ACKNOWLEDGE READING:

INSTRUCTIONS FOR MYELOGRAM PATIENTS

1. For the remainder of the day after the myelogram, rest with your head elevated on two pillows. You may walk to the bathroom, but otherwise, remain at rest with your head elevated 30 degrees. Use your preferred pain reliever for headache.
2. Drink 8 oz. of the fluid of your choice every 1 to 2 hours
And eat whatever you wish.
3. If you have **new pain** which persists more than 24 hours after the myelogram, call our center at: **404-257-1858**.

PATIENT

SIGNATURE: _____ **DATE:** _____

----- DO NOT WRITE BELOW LINE -----

DISCHARGED BY: _____ **TIME:** _____
Signature of radiologist

FILMS MAILED _____

FILMS GIVEN TO PATIENT _____