SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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CONSENT FOR PROCEDURE

Patient Name_____ DOB Age/ Sex _____

Diagnosis_____ ICD-9_____ CPT_____

Diagnosis_____ ICD-9_____ CPT_____

Proposed Treatment or Procedure_____

To be performed at the following faculity_____

Physician performing the procedure_____

I, the undersigned patient, understand that this procedure involves potential risks. These risks may include, but not limited to injury to teeth or airway, damage to vocal cords, awareness during general anesthesia, infection, drug reactions, allergic reactions, aspiration, lung injury, kidney injury, liver injury, hemorrhage, hematoma, loss of limb function, paralysis, residual sensation, persistent weakness or numbness, complications of blood transfusions, pain, discomfort that may continue after discharge, increased pain, loss of sensation, headaches, injury to arteries or veins, bleeding, nerve injury, blood clot, respiratory problems, cardio-pulmonary compromise, brain injury, loss of life.

I, the undersigned, understand there is always the possibility of unexpected risk or complications not discussed, and no guarantees or promises have been made concerning the results of the procedure or treatment. The potential benefits, risks and available alternative of the proposed procedure or treatment have been explained. Also, during the course of the proposed procedure or treatment unforeseen conditions may require the performance of emergent procedures and I authorize such procedures to be preformed. Additional Comments: You may also experience: _____

_____

I received educational information in writing and verbally regarding _____

I understand I must have nothing to eat or drink eight hours before any given procedure or anesthesia.

I, the undersigned have disclosed any anti-platelet medication or other medication that can affect blood clotting and have read the SXM Clinic "Anticoagulation Policy".

I have read the above consent. All of my questions have been answered, and I consent to the above stated procedure.

_____	_____	_____
Signature Patient Representative/ Legal Guardian	Printed Name & Relationship	Date/time
_____	_____	_____
Witness Signature	Printed Name	Date & Time

I, the undersigned physician, have explained to the patient or patient's representative the nature of his/her condition, the name of the proposed procedure or treatment, the risks, benefits and alternatives of the procedure as well as non-treatment and adverse reactions that may be reasonably expected to occur. All of the patient or patient's representative questions were answered.

_____	_____	_____
Signature	Printed Name	Date & Time