



## INFORMED PATIENT CONSENT FOR INJECTION

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Procedure being completed \_\_\_\_\_

### Questionnaire

Please list your allergies if any

\_\_\_\_\_

Please list your current medications if any

\_\_\_\_\_

Please list any previous surgeries if any

\_\_\_\_\_

### Patient Information

Your doctor has asked us to perform a test that requires an injection into a joint, adjacent to a nerve or into other soft tissue structure. This procedure determines whether a particular joint or nerve is causing your pain and may help resolve your pain. By signing this form you are indicating that the procedure and possible side effects have been explained to you by a Radiologist, Radiographer, Sonographer or Nurse and you fully understand the implications and risks.

### Patient Consent

I understand and accept the risks involved in this procedure. I hereby consent to the

procedure which will be performed by \_\_\_\_\_  
(Radiologist Name)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Patient)

Name \_\_\_\_\_  
(Interpreter if present)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Interpreter if present)