AUSTIN
NEUROMUSCULAR
CENTER

LUMBAR PUNCTURE CONSENT FORM

TO THE PATIENT

This form and your discussion with your doctor are intended to help you make an informed decision about your biopsy. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. You should consider all the above, including the option of declining treatment, before deciding whether to proceed with the planned procedure. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

I voluntarily request for Austin Neuromuscular Center physicians & associates, technical assistants, and other healthcare providers as they may deem necessary, to treat a condition that has been explained to me. I understand that the following procedure(s) is planned for me, and I voluntarily consent and authorize the following procedures: **LUMBAR PUNCTURE AT L5/S1 SPINE**

1. I understand that my physician may discover other or different conditions which require additional or different procedures than those planned.
2. I authorize Austin Neuromuscular Center physicians & associates, technical assistants, and other healthcare providers to perform such other procedures which are advisable in their professional judgment.
3. I understand that no warranty or guarantee has been made to me as a result or cure.
4. Just as there may be risks and hazards in continuing with my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, or diagnostic procedure planned for me. I realize that common to surgical, medical, and other diagnostic procedures are the potential for infection, blood loss, allergic reaction, and even death.
5. I reviewed the lumbar puncture procedure fact sheet that was provided to me, and I understand the indication and side effects of the procedure.
6. I understand that anesthesia involves additional risks and hazards, but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedures.

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7. I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reactions, paralysis, allergic reactions, or even death.
8. I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures planned to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.
9. I was given an opportunity to review educational material regarding my procedure and my questions and concerns were addressed.
10. I consent to the disposal of any tissue or other biomedical waste.
11. I certify that this form has been fully explained to me, that I have read it, or it has been read to me, that the blank spaces have been filled in, and that I understand its contents.

Patient Name: _____ DOB: _____

Patient/Legal Guardian: _____ Date/Time: _____

_____

Witness Name

_____

Witness Signature

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