CONSENT FOR PLATLET RICH PLASMA INJECTION

A. CONSENT FOR PROCEDURE

1. I authorize _____ to perform the following procedure(s):

_____

Specific Location — Indicate laterally, right, or left

I understand that the physician may need to perform other urgent procedures that were unanticipated. I consent to the performance of any additional procedures determined during my original procedure to be in my best interests and where delay may cause additional harm.

I understand that other qualified practitioners, including residents (doctors who have finished medical school and are getting more training), may be chosen to do or help with procedures. All qualified practitioners will only perform tasks that are within their scopes of practice and for which they have been granted clinical privileges. Residents will only perform all or parts of the procedures under the supervision of my doctor.

I understand my diagnosis/condition to be:

2. I have been told about what results to expect, which includes information about the chances for the expected results and about problems that might occur during recuperation. I know that the results cannot be guaranteed. I have been told about and understand the risks and benefits of the procedure(s) listed above. I understand that there are risks for all kinds of procedures. These risks, which can be serious, include bleeding, infection, and damage to nearby tissues, vessels, nerves, or organs. They may result in paralysis, cardiac arrest, brain damage, and/or death. Other risks for this procedure may include: headache, no decrease in pain, or an increase in pain. I understand that the risks of steroid medication include: fluid retention, increased blood pressure, and increased blood sugar if I am a diabetic, mood changes, lowered resistance to infection, and other effects that usually last up to 10 days after injection.

3. I understand the alternatives to the proposed procedure. I understand the risks of the alternative procedures.

4. I understand photographs and/or video or electronic recordings may occur during my procedure and may be used for internal performance improvement or educational purposes. In many instances, photographs, digital images, and/or videos may be required for insurance and billing purposes.

5. I understand that any tissues or parts removed during my procedure may be disposed of by the practice or used for any lawful purpose including education and research.

6. CONSENT FOR SERIAL PROCEDURES (when applicable)

☐ I consent to the above as a series of the same procedure over a 6 month period of time:

_____/_____/_____ to _____/_____/_____

B. CONSENT FOR ANESTHESIA OR SEDATION

1. When local anesthesia and/or sedation is used by the physician previously stated in section A1:
   I consent to the administration of such *local anesthetics* as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

   I consent to the administration of *sedative medications* by or under the direction of the physician named in section A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by qualified personnel. I consent to care provided by the physicians qualified to administer anesthesia. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic ("being put to sleep") and/or a nerve block. I understand the risks of anesthesia may include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

C. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

_____	_____	_____	_____
Signature of patient or legal representative	Printed Name	Date	Time

D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or his/her representative has communicated to me that they understand the contents of this form.

_____	_____	_____	_____
Signature of physician or designee obtaining consent	Printed Name	Date	Time

_____	_____	_____	_____
Signature of witness (optional)	Printed Name	Date	Time