Affix Patient Label	
Patient Name:	Date of Birth:

Attending/supervising physician:____

Resident physician (if applicable):______________________________ Type of supervision: ___Direct ___Indirect

This information is given to you so that you can make an informed decision about **Lumbar Puncture.**

Reason and Purpose of the Procedure

Spinal fluid is clear fluid that delivers nutrients and cushions the brain and spinal cord. In a lumbar puncture a small needle is inserted in the lower back. This needle goes into fluid spaces in the spinal canal. A small sample of that fluid is collected for testing.

Benefits of this Procedure

Your child might receive the following benefits. Your child's doctor cannot promise your child will receive any of these benefits. Only you can decide if the benefits are worth the risk. A lumbar Puncture is done to:

- Diagnose diseases of the brain and spinal cord.
- Help decide how to treat the disease in the best way.
- Help some of my child's symptoms get better (with certain diagnoses).

Risks of Procedure

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- A small amount of bleeding at or around the puncture site. A band-aid is usually all that is necessary to stop this.
- The procedure may be successful or multiple attempts may be necessary.
- Spinal fluid may continue to leak from the site. A second procedure may be required to stop the leak of spinal fluid.
- Infection in the skin, bone or spinal fluid space. If this occurs, your child may need to be placed on additional antibiotics to treat the infection.
- Headache that can be severe and last several days. This occurs in up to 40% of older children. If this occurs, laying flat in bed and drinking lots of fluids can help the headache. Your child may also need medicine to treat the headache.
- Backache is common especially at the time of the procedure. If this occurs, your child may need medicine to treat the backache.
- Leg pain at the time of the procedure. If this occurs, it will usually go away when the needle is removed.
- Brain injury. This is a very rare complication in patients with increased pressure inside their head. If this occurs it can lead to death or severe disability.
- Allergic reaction to the medicines or instruments used in this procedure. If this occurs your child may need medicine to treat the reaction.

Risks Associated with Smoking

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to your Child

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Alternatives to this Procedure

- You can decide not to have the test or procedure for your child. I know there can be serious results if I make this choice.

If You Choose not to let your child have this Procedure

- You child's doctor may not have the information needed to treat your child in the best way.
- You child's condition may worsen and his/her life could be threatened.

General Information

- The procedure may need to be repeated. Other procedures may be needed.
- The doctor can take steps to decrease some of the risks. This is a sterile procedure to decrease the risk of infection.
- My child's doctor will take steps to decrease my child's discomfort during the procedure. This may include a numbing cream and local anesthesia.
- The doctor may also order a CT scan for my child.
- During the procedure the doctor may need to do more tests or treatment.
- Spinal fluid taken from my child's body may be tested. It may be kept for research teaching or the hospital may discard the fluid in a proper manner.
- Students, technical sales people and other staff may be present during the procedure. My child's doctor will supervise them.
- Pictures and videos during the procedure. These may be added to my child's medical record. These may be published for teaching purposes. My child's identity will be protected.

By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want my child to have this procedure: **Lumbar Puncture**
- I understand that my doctor may ask a partner to do the surgery/procedure.
- I understand that my doctor may ask another doctor with the same qualifications to do the sedation.
- I understand that other doctors, including medical residents or other staff may help with sedation. The tasks will be based on their skill level. My child's doctor will supervise them.

Parent/Guardian Signature____ Date:_____________ Time:_________
Relationship: ☐ Patient/Parent of Minor ☐ Closest relative (relationship)________________ ☐ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter signature:____ Date:_____________ Time:_________
(if applicable)

For Provider Use ONLY:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:____ Date:______________ Time:____________

Teach Back
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: ____
____ Area(s) of the body that will be affected: ____
____ Benefit(s) of the procedure: ____
____ Risk(s) of the procedure: ____
____ Alternative(s) to the procedure: ____

OR
____ Patient elects not to proceed: ___________________________________ Date:__________ Time:___________
(patient signature)
Validated/Witness:____ Date:___________Time:_________