BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Lumbar Puncture

This information is given to you so that you can make an informed decision about having a **lumbar puncture.**

Reason and Purpose of this Procedure:

A lumbar puncture removes cerebral spinal fluid from your spine. This helps the provider understand what is causing your illness. You will lay on your side or prone for this procedure. The provider injects medication in your back to numb the skin. A needle is inserted into your back and the fluid is collected. A lumbar puncture may also be performed to lower the pressure of the fluid (cerebrospinal fluid) in your brain.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- A lumbar puncture can give lifesaving information that will help your provider to treat you. It can also be a lifesaving measure if done to lower the pressure of the fluid in your brain.

General Risks of Procedures:

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.

- Reaction to local anesthesia. Tell your provider if you are allergic to any of the anesthetics used in this procedure.
- Pain or discomfort during the procedure. Your provider will try to ease the discomfort, but you may feel pain.

Risks of this Procedure:

- **Bleeding.** The procedure may cause bleeding into the spinal canal or surrounding area. Severe bleeding may need more treatment or surgery. Tell your provider if you have blood-clotting problems, or if you are taking blood thinners.
- **Herniation.** Although extremely rare, there is a risk of brain herniation after a lumbar puncture. Herniation is when the brain shifts or moves. The pressure on the brain can cause brain damage or death.
- **Infection.** Infection at the puncture site, under the skin or central nervous system (the brain and the spinal cord). You may
- need antibiotics or further treatment.
- **Lumbar puncture headache.** You may have a mild to moderate headache after the test. Drinking lots of fluids, especially those with caffeine like coffee, cola or tea can reduce the headache pain. Lying flat after the test will also reduce headache pain. Rarely, a severe headache that will not go away may need further treatment.
- **Nerve root trauma.** There is a low risk of transient radiculopathy (shooting pain down the leg). This could come from damage to the nerve roots from the needle or catheter. It is very important to stay as still as possible during the procedure to reduce this risk.

Potential Radiation Risks:

- **Any exposure to radiation may cause a slightly higher risk for cancer later in life.** This risk is low.
- **Skin rashes.** Skin rashes may lead to breakdown of skin and possibly severe sores. This is rare.
- **Hair loss.** This does not happen to everyone. This can be temporary or permanent.
- **It is possible we may have to use higher doses of radiation.** If we do, we will tell you.
- **If you see changes with your skin, you should report them to your doctor**.

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.

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Risks Specific to You:

Alternative Treatments:

Other choices:

- Blood tests or x-rays.
- Do nothing. You can decide not to have the procedure.

If you Choose not to have this Treatment:

- Your provider may not be able to diagnose your condition in order to treat it quickly.
- If this is an emergency situation, not having it done may decrease your chance of survival.

General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure, the doctor may need to do more tests or treatment.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical salespeople, and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be taken during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

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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 to have this procedure: **Lumbar Puncture** _____

  _____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to procedure. If so, please obtain consent for blood/products.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Closest relative (relationship) _____ ☐ Guardian/POA Healthcare

Reason patient is unable to sign: _____

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

Telephone Consent ONLY: *(One witness signature MUST be from a registered nurse (RN) or provider)*

1st Witness Signature: _____ 2nd Witness Signature: _____ Date: _____ Time: _____

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:

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: _____