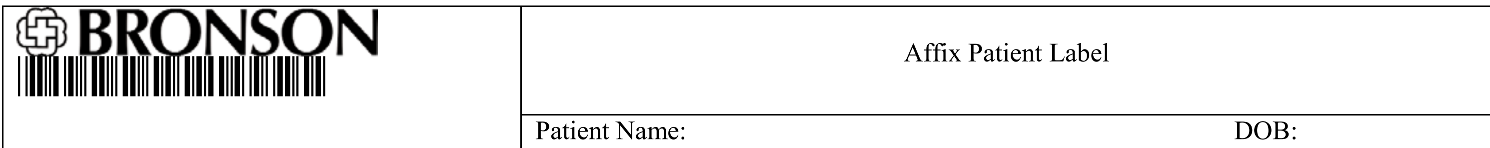

Informed Consent Arthogram

This information is given to you so you can make an informed decision about having an injection for an **arthrogram.**

Body location: ____

The radiologist or physician assistant will use X-ray fluoroscopy or in some cases, ultrasound or computed tomography (CT), to guide placement of a small needle into____. The site will be prepped with antiseptic. Local anesthetic will be injected at the procedure site.

Reason and Purpose of the Procedure

- Inject dye into the joint for your MRI, CT, or X-ray arthrogram exam.

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.

- Improve the diagnostic accuracy of your CT, MRI, or X-ray exam.
- Help your doctor decide how to treat you.
- Surgical planning.
- Other: ____.

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.

General risks of joint injection procedures

Significant complications from arthrogram joint injections are very rare.

- **Joint pain**: You might have worse pain for a few days. This usually improves by taking over-the-counter pain medicine.
- **Joint infection:** This is very rare. You might need antibiotic treatment or surgery. Joint infections can even result in death.
- **Allergic reaction to medicine:** This is rare. You might need medicine.
- **Bleeding:** Significant bleeding is very rare, even if you take blood thinners.
- **Injury to nerves or other body structures by the joint:** This may require additional treatment.

Risks Specific to You

____

____

____

____

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.

Alternative Treatments

Other choices:

- Do nothing. You can choose not to have this procedure.
- Other:____

If You Choose Not to Have this Treatment

- It may not be possible to get the information your doctor wants.
- You might not get treated for your problem without an accurate diagnosis.
- Other: ____

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 sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My 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 to have this procedure: **Joint Injection for an Arthrogram**________________________________
- I understand that my doctor may ask a partner to do the surgery/procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. 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 surgery. IF so, please obtain consent for blood/product.

Patient Signature____Date:__________Time:_________

Relationship: ☐ Patient ☐ 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: ____Date:___________Time:__________

Interpreter (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:_________