BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Myelogram

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

Reason and Purpose of the Procedure

- To help the doctor diagnose the cause of your problem.

A myelogram involves injecting x-ray dye into your spinal canal. This is done to assess the nerve roots in your spine.

The doctor injects medicine in your back to numb the skin. A small needle is inserted into your spinal column (lumbar puncture) and the dye is injected. Most people tolerate the procedure with little discomfort. Your doctor will use X-ray fluoroscopy (a continuous X-ray that is transmitted to a monitor) to guide needle placement. A CT scan may be done after the injection.

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.

- To help the doctor diagnose the cause of your problem.
- To help your doctor decide on the best treatment.

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.

Risks of this procedure

- **Reaction to local anesthesia**. Tell your doctor if you are allergic to any anesthetics.
- **Pain or discomfort during the procedure.** Your doctor will give you medicine to prevent pain but you may still feel discomfort.
- **Bleeding.** You may have bleeding into the spinal canal or surrounding area. Severe bleeding may need more treatment or surgery. Tell your doctor if you have blood-clotting problems, or if you are taking blood thinners.
- **Herniation**. This is when the brain shifts or moves. The pressure on the brain can cause brain damage or death. This is extremely rare.
- **Infection**. This can happen at the puncture site, under the skin or central nervous system (the brain and the spinal cord.) You may need antibiotics or more treatment.
- **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. You will be instructed to lie flat after the test. That will also reduce headache pain. Rarely, a severe headache that will not go away may need treatment.
- **Nerve root trauma.** There is a low risk of damage to the nerve roots from the needle or catheter. This can cause shooting pain down the leg (transient radiculopathy). It is very important to stay as still as possible during the procedure to reduce this risk.
- **Reaction to the x-ray dye.** The dye may increase the chance of headache. It can also cause nausea and vomiting. Dye may also increase the chance of having a seizure for some patients. Let your doctor know if you have ever had an allergic reaction to x-ray dye.

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 You

_____
_____
_____
_____

Alternative Treatments

Other choices:

- MRI or other X-rays.
- Do nothing. You can decide not to have the procedure.

If You Choose Not to Have this Treatment

- Your doctor may not be able to diagnose your condition.

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.

BRONSON	Affix Patient Label
	Patient Name: DOB:

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: **Myelogram**_____.
- 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:_____