UNITED RADIOLOGY

Affix Label Here

INTERVENTIONAL RADIOLOGY CONSENT FORM

PROCEDURE: ………………………………………………………………………………………………….

For your safety, please answer these questions truthfully. If unsure, leave blank and discuss with the Radiographer.

Question	Answer
Do you have diabetes? **If yes, please list any medication:**	Yes ☐ No ☐
Do you have any allergies to food or medicine? **If yes, please list:**	Yes ☐ No ☐
Do you take Blood Thinners? **If yes, which one do you take and when did you take them last:**	Yes ☐ No ☐
GENERAL RISK OF PROCEDURE • INFECTION • BLEEDING • BRUISING • PAIN AT INJECTION SITE	

CONSENT TO PROCEDURE BY PATIENT OR GUARDIAN

I have been informed of and understand the proposed treatment for myself/the patient's name above.

The doctor has explained the risks & problems specific to me/the patient, including the outcomes & possible complications.
I understand and agree to pay any fees incurred for this treatment, including external pathology fees if this service is required.

Full Name: ……

Patient signature: …………………………………………………… Date: …………/…………/…………

OFFICE USE ONLY

I, Dr. ……………………………………………………… have explained the procedure and risks.

Radiologist signature: ……………………………… Date: …………/…………/…………

Medication Used

CSI: ……………………………………………………… Expiry: ……………………………

Local Anaesthetic: ……………………………………. Expiry: ……………………………

Euflexxa: ……………………………………………….. Expiry: …..…………………………

Radiographer/Sonographer Initials: ………………………