Providence
St. Jude Heritage
Medical Group

CONSENT TO TESTING, MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any testing, procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned diagnostic testing, procedure or treatment.

I authorize Dr. Paolo Jorge, MD and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him to perform the following:

NCS and EMG (commonly known as Muscle and Nerve Test)

and/or to do any other testing, procedure, or treatment that in their judgment may be advisable to my well-being, including such tests, procedures or treatments as are considered medically advisable to remedy conditions discovered during the above test, procedure or treatment.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the testing, procedure or treatment which are described generally here. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.
- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this test, procedure or treatment including: ***Numbness or Nerve Damage***
- **ALTERNATIVE METORS OF TREATMENT.** I am satisfied with my understanding of alternative tests, procedures or treatments and their possible benefits and risks including: ***This is a Diagnostic Test, the Alternative is to not have it completed.***
- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no testing, procedure or treatment is rendered.
- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed test, procedure or treatment.
- **ADDITIONAL OR DIFFERENT ACTION DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform tests, procedures or treatments different from, or in addition to, the test, procedure or treatment described above. I authorize and consent to the performance of such additional or different test, procedure and/or treatment as are considered necessary and advisable.
- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.
- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the test, procedure or treatment for educational or diagnostic use.
- **NO GUARANTEES.** I understand there are risks involved in any test, procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the test, procedure or treatment and all of my additional questions about the test, procedure or treatment have been answered.

I have read and been offered a copy of this form.

Print Name: _____ Signature: _____

Date: _____ Time: _____

Physician: _____ Witness: _____

LABEL