



Patient agreement to investigation or treatment - To be retained in patient's notes

Patient details (or pre-printed label)
Patient's surname/family name..... Patient's first names.....
Date of birth ..... Male Female
Responsible health professional..... Job title .....
NHS number (or other identifier)..... Special requirements.....
(eg other language/other communication method)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear) ..... Transforaminal Epidural Steroid Injection (TESI) / Selective Nerve Root Block (SNRB)

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:
The intended benefits ... Decreased back and leg pain.....

Serious or frequently occurring risks ... Persistent pain, recurrence of pain, dural puncture, intravascular injection, infection, bleeding, neurological complications including numbness, paralysis and bladder dysfunction, arachnoiditis, requirement for further intervention etc.....

Any extra procedures which may become necessary during the procedure
blood transfusion.....
other procedure (please specify) .....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided .....

This procedure will involve:
general and/or regional anaesthesia local anaesthesia sedation
Signed:..... Date ..
Name (PRINT) ..... Job title .....

If you have further queries please telephone PALS service on 0808 145 2001 and they will put you in touch with the appropriate staff.

PLEASE TICK HERE IF THE FOLLOWING STATEMENT IS NOT APPLICABLE o

Statement of interpreter
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.
Signed ..... Date .....
Name (PRINT) .....

Top copy accepted by patient: yes/no (please ring)

# Statement of patient

Patient identifier/label

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 1 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

**I agree** to the proposed procedure.....

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....  
.....  
.....  
.....

Patient's signature ..... Date.....

Name (PRINT) .....

**A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).**

Signature ..... Date .....

Name (PRINT) .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed:..... Date ..

Name (PRINT) ..... Job title .....

### Important notes: (tick if applicable)

See also advance directive/living will (eg Jehovah's Witness form)

Patient has withdrawn consent (ask patient to sign /date here)

.....(Signature).....(Date)