



Metro Denver Pain Management

1260 S. Parker Rd. Ste. 200
Denver, CO 80231

Christopher J. Huser, M.D.
Kevin T. Smith, M.D.

EVIDENCE OF INFORMED CONSENT TO OPERATION OR OTHER PROCEDURE

1. OPERATION PROCEDURE AND ALTERNATIVE

I, _____ (patient or guardian), authorize either Kevin T. Smith, MD. Christopher J Huser, MD and/or their assistants as may selected by him/her to perform the following procedure or operation:

I understand that the procedure is: _____

Alternatives include: _____

2. **RISK:** This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Common: Backache or Neck Ache, discomfort at the injection site or Increased pain, bruising from needles. Not Common: Bleeding, Infections, Nerve Damage, Drug Allergy or reaction to Contrast Dye, Irregular Heartbeat, Temporary weakness, Nausea and Vomiting, Headache, increase in symptoms. Rare: Breathing Problems, Deflated Lung, Catheter Problems, Stopping of the Heart, Seizure, Paralysis, Brain Damage, Death.

3. **ANESTHESIA:** The administration of anesthesia also involves risk, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthesia as may be considered necessary by the person responsible for these services.

4. **ADDITIONAL PROCEDURES:** If my physician discovers a different, unsuspected condition at the time of surgery, I authorized him/her to perform such treatment as he/she deems necessary.

5. I understand that no guarantee or assurance has been made as to the results of the procedure(s) and that they may not cure the condition.

6. I consent to the above operation or procedure(s) being witness by students or practitioners in the health sciences in connection with their continuing education.

7. I authorize this facility to preserve and examine for scientific, pathological, or teaching purposes or to otherwise dispose of, the tissue or organs resulting from the operation or procedure(s) authorized above.

8. **PHOTOGRAPHY:** The undersigned hereby authorizes the taking of photographs or film during a surgical or other procedure to be used only for the purposes of medical study or research. This consent is expressly intended to release from liability all personnel of the clinic, as well as the operating physician, consultants and the attending physician.

9. **PATIENT'S CONSENT:** I have read and fully understand this consent form, and understand I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

10. **TRANSFER:** I understand in the rare event that hospitalization is required, my physician will arrange for my transfer to a local hospital.

IF YOU HAVE ANY QUESTIONS AS TO THE RISK OR HAZARDS OF THE PROPOSED SURGERY OR TREATMENT, OR ANY QUESTIONS CONCERNING THE PROPOSED SURGERY OR TREATMENT, ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THIS CONSENT FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM!

PATIENT OR PERSON WITH AUTHORITY TO SIGN

WITNESS

Date Time

Date Time

PHYSICIANS DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions and, to the best of my knowledge, I feel the patient has been adequately informed and has consented.

PHYSICIAN SIGNATURE

Date Time

Reason Patient cannot sign is: _____