patient information

Consent for Procedure or Treatment Form

CONSENT

I hereby authorize Dr George Koulouris and such assistants as have been selected to perform the following procedure or treatment:

☐ CT guided injection ☐ FNA/Biopsy

☐ US guided injection ☐ Other _____

- I have received the relevant information verbally and/or fact sheet and had the opportunity to ask questions.
- I am aware of the side effects, common risks and complications of the procedure, however, acknowledge that unforeseen complications may occur.
- The procedure has been explained to me in a way that I understand.
- I hereby consent to the following procedure or treatment and am satisfied with the explanation.

PATIENT NAME (Print) (OR GUARDIAN): SIGNATURE DATE

WITNESS NAME SIGNATURE

STAFF USE ONLY

Correct patient name	Yes ☐	No ☐
Correct side examined	Yes ☐	No ☐
Consent form signed	Yes ☐	No ☐
Info sheet read	Yes ☐	No ☐
Pathology test included	Yes ☐	No ☐

[Last Updated: 14/12/2010]

melbourneradiologyclinic

For All Appointments ph: 03 9667 1667

Melbourne Radiology Clinic
ABN 68 134 592 911
3-6/100 Victoria Parade, East Melbourne VIC 3002

t 9667 1667 f 9667 1666
enquiries@melbourneradiology.com.au
www.melbourneradiology.com.au

Copyright © 2009-2010 Melbourne Radiology Clinic. All Rights Reserved.