ENCOMPASS
MEDICAL GROUP

CONSENT TO PROCEDURE OR TREATMENT

Date:_____ Time:_____

I hereby authorize _____and whomever he may designate as
(Physician)
his assistants to perform upon _____ at Encompass Medical
(Name of patient or "myself")
Group the following procedure_____.
(Description of procedure)

I have been informed and understand the nature and purpose of the procedure; the probable consequences thereof; the possibility of occurrence of complications has been explained and is understood by me, and I acknowledge that no guarantee or assurance has been made as to the results to be obtained.

It has been explained to me that during the course of the procedure; unforeseen conditions may be revealed that necessitate an extension of the procedure or a different procedure than that set forth above. I hereby authorize and request the above-named physician or his designated consultant to perform such procedures that are necessary and desirable in the exercise of the physician's professional judgement. The authority granted shall extend to the treating all conditions that require treatment, which are not known to the physician at the time the procedure commenced.

I also consent to the pathological study and retention or disposal of any tissue or parts, which may be removed during the above procedure.

I certify that I have fully read and understand the above consent to procedure or treatment, that the explanations therein referred to were made, and that all my questions regarding this procedure have been completely answered.

WITNESSES TO SIGNATURES:

_____ _____
(Signature of witness) (Signature of patient)

_____ _____
(Printed name/witness) (Printed name/patient)

_____ _____
(Signature of radiologist) (Signature of person authorized to consent, If other than patient)

_____ _____
(Printed name/radiologist) (Authority to consent-relationship)

ENCOMPASS
MEDICAL GROUP

CONSENT TO ORAL DIAZEPAM

Date:_____ Time:_____

I hereby authorize _____ (Radiologist) and whomever he designates to administer oral diazepam_____(*Name of Patient)* at Encompass Medical Group.

I have been informed and understand the nature and purpose of the administration of the oral diazepam. This medication is to aid you in reducing your anxiety to have your procedure performed today.
_____ *(Initials)*

The side effects of oral diazepam might include drowsiness, dizziness, fatigue, constipation, blurred vision or headaches. If any of these side effects persist or worsen, please notify your physician promptly.
_____(*Initials)*

Do you currently take any other type of oral diazepam? Yes_____ No_____
This includes alprazolam and lorazepam.
Do you have a driver with you today: Yes_____ _No_____
Are you currently pregnant or breast feeding: Yes _____ No_____

I certify that I have fully read and understand the above consent to the administration of oral diazepam and agree that I understand that potential side effects. I further understand that I should not drive, drink alcohol, or operate dangerous equipment for the next 24 hours. Your physician will be notified that we are providing this oral diazepam for your procedure today.

WITNESSES TO SIGNATURES:

_____ (Signature of technologist)

_____ (Signature of patient)

_____ (Printed name/technologist)

_____ (Printed name/patient)

_____ (Signature of radiologist)

_____ (Signature of person authorized to consent, If other than patient)

_____ (Printed name/radiologist)

_____ (Authority to consent-relationship)

I hereby certify that I will be driving the above consented patient home today.

_____ (Signature of Driver)

PREMIER IMAGING
Focused on Providing Superior and Expanded Imaging Care
Encompass Medical Group

CONSENT TO PERFORM CT CORONARY ANGIOGRAPHY

Date:_____ Time:_____

I hereby authorize _____(*Radiologist)* and whomever he may designate to perform_____ (*Name of Patient*) at Encompass Medical Group/Premier

The procedure's nature, purpose, likely consequences, and possible complications have been explained to me, and I understand them. I acknowledge that no results have been guaranteed or assured.

I understand that unforeseen conditions discovered during the procedure may require extending it or performing a different procedure. I authorize and request the above-named physician or designated consultant to perform procedures considered necessary and desirable in the physician's professional judgment. This authorization includes treating all conditions requiring treatment that were unknown to the physician when the procedure began.

I also consent to the pathological examination and retention or disposal of any tissue or parts removed during the procedure.

I certify that I have fully read and understand the above consent to procedure or treatment, that the explanations therein referred to were made, and that all my questions regarding this procedure have been completely answered.

WITNESSES TO SIGNATURES:

_____ (Signature of technologist)

_____ (Signature of patient)

_____ (Printed name/technologist)

_____ (Printed name/patient)

_____ (Signature of radiologist)

_____ (Signature of person authorized to consent, If other than patient)

_____ (Printed name/radiologist)

_____ (Authority to consent-relationship)