NorthStar RADIOLOGY

CONSENT FOR INVASIVE PROCEDURE

Date of Service **Referring physician name** **Phone Number:**

Patient Name: **Date of Birth:**

I hereby consent to and authorize North Star Radiology, its doctors, technicians and medical personnel to perform a:

Type of exam **Date**

- ☐ **Benefits:** I understand the reason/benefits for the procedure as explained to me. I also understand that there may be a needle or other instruments inserted into my body.
- ☐ **Alternatives:** I understand the alternatives to this procedure as explained to me by my physician.
- ☐ **Risks:** The risks of injury, infection, bleeding and other complications, despite all precaution have been explained to me. All questions that I may have in reference to this procedure and its associated risks have been explained to my satisfaction.
- ☐ **Outcome & Recovery:** Results of any surgical or invasive procedure cannot be guaranteed. I also understand that I may encounter limitations or problems related to recuperation.

- ☐ I have had the opportunity to ask questions about the procedure and I have had my questions satisfactorily answered. I hereby consent to having the surgical/invasive procedure performed.
- ☐ I am or think I may be pregnant ***if this is checked, please inform the technician before your procedure.**

X Signature of patient **Date**

X Signature of guardian or authorized person to consent for this patient **Date**

PHYSICIAN DECLARATION: I have reviewed and explained the information listed above to the patient/legal representative and answered all the patients questions to the best of my knowledge. I have discussed the risks, options and expected outcomes with the patient. The patient/legal representative verbally demonstrates understanding of the information and has signed the consent form.

Print Form Reset Form

X Signature of Radiologist **Date**