CONSENT FOR INVASIVE PROCEDURE

Patient First and Last Name: _____

Date of Birth: _____/_____/_____ Referring Provider Name: _____

I hereby consent to and authorize Bellingham Advanced Medical Imaging, its doctors, technicians and medical personnel to perform:

Type of Exam(s): _____

Date of Exam: _____/_____/_____

Please review and check the boxes below to verify consent and understanding of the following:

- ☐ **Benefits**: I understand the reason(s) / benefit(s) 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 doctor.
- ☐ **Risks**: The risks of injury, infection, bleeding and other complications despite all precautions have been explained to me. All questions that I have about this procedure and its associated risks have been explained to my satisfaction.
- ☐ **Outcome and Recovery**: Results of any surgical or invasive procedure cannot be guaranteed. I also understand that I may encounter limitations or problems related to recuperation.
- ☐ **Questions**: I have had the opportunity to ask questions about the procedure and have had my questions satisfactorily answered.
- ☐ **Pregnancy**: I am or think I may be pregnant. If yes, please inform the technician **before** the procedure.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature: _____ Date: _____/_____/_____

RADIOLOGIST / PHYSICIAN DECLARATION

I have reviewed and explained the information listed above to the patient / legal representative and answered all patient questions to be 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.

Radiologist Signature: _____ Date: _____/_____/_____

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