The Shin J. Oh Muscle and Nerve Histopathology Laboratory at UAB

Patient Legal Consent

Consent to Operation(s), Administration of Anesthetics, Transfusion of Blood Products or Other Procedures, and/or Retention or Disposal of Tissue, Organs, or Severed Members

Name of Patient _____ MRN _____

Procedure: ___ Muscle Biopsy ___ Nerve Biopsy ___ Skin Biopsy ___ Lumbar Puncture

1. Consent: I authorize and direct Dr. Eroboghene Ubogu and/or his associates to perform the above named procedures upon me. I have reviewed my clinical condition with my physician including the anticipated benefit to be obtained from such procedures, the risks of the procedures and alternatives. While no guarantee has been made as to the results or any planned treatment, I understand that this is administered in the best judgment of the physician to benefit me. I also understand that physicians-in-training may participate in this procedure, under the supervision of my physician, at a level of involvement deemed appropriate by my Attending Physician.
2. Medications & Procedures: I further understand that with any procedures, administration of medications including anesthetics, includes certain risks. I understand that consideration of the risks is weighed into the medical decision that is made by my physician in order to benefit me.
3. Blood Products: I further understand that with any procedures, an unforeseen condition may arise that may require the transfusions of blood/blood products. I request and authorize my physician, in his or her best judgment, to direct any further therapeutic means to improve my condition.
4. Additional Services: In the course of the above named procedure, certain unforeseen conditions may arise that may require additional services including operations, procedures, administration of medication and invasive monitoring techniques. I request that my physician, in his or her best judgment, direct any further therapeutic means to improve my condition.
5. Scientific and Educational Purposes: I do hereby authorize and direct by physician or the pathologist to examine, retain for scientific and/or educational purposes, or dispose of all such tissues, organs, or bodily fluids that shall be removed by operation or biopsy performed upon me. I understand that my identity will be concealed and my privacy maintained.
6. Consent to Videotape/Photograph: I understand and consent that certain procedures are routinely videotaped or photographed at the request of the physician and may be used by him/her in the diagnosis and documentation of medical conditions and/or purpose of medical education. I further understand that my identity will be concealed and my privacy maintained if any materials are used for educational purposes.
7. Sharp Instruments: I understand this procedure will require the use of sharp instruments. Therefore, in the event that a member of the clinical staff punctures his/her skin, I give consent for staff to perform all necessary serologic testing for HIV and any other blood-borne infections, and disclose to appropriate personnel as may be otherwise required by state or federal law.

Patient Signature _____ Date _____ Time _____ Witness_____ Date _____

If the patient is a minor or unable to sign, complete the following:

Patient is a minor _____ or unable to sign, because _____

Parent/Guardian/Other Person and Relationship _____ Date _____

I have discussed the procedure named above, including its relevant risks, benefits, including potential problems related to recuperation, and side effects related to alternatives including the possible results of not receiving care, treatment, and services. The patient/family understands and acknowledges that questions were answered to their satisfaction and requests to proceed.

Physician _____ Date _____