Tampa Bay Neurology,Inc

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CONSENT FOR EMG AND NERVE CONDUCTION STUDY

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended treatment so that you can make an informed decision whether or not to undergo the treatment or procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so that you may give or withhold your consent to treatment.

1. I voluntarily request my physician to perform an **EMG(Electromyography) & Nerve Conduction Study.**

2. I understand that there may be risks and undesirable consequences associated with this procedure. The possible risks or undesirable consequences associated with an EMG/Nerve Conduction Study include, ***but are not limited to:*** **bruising, swelling or inflammation at the needle insertion site(s); infection at the site(s); nerve damage.**

3. I have been given an opportunity to ask questions about the procedure and the risks and undesirable consequences involved, and I believe that I have sufficient information to give this informed consent.

X_____ _____
Patient or Guardian's Signature Date

_____ _____
Patient's printed name DOB

The Patient/Authorized Individual has read this form or has had it read to him/her. The Patient/Authorized Individual states that he/she understands this information. The Patient/Authorized Individual has no further questions.

_____ _____
Signature of Witness Date

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternative to, the proposed procedure(s), have offered to answer any questions and have fully answered all such questions. I believe that the patient fully understands what I have explained and answered.

_____ _____
Physician Signature Date