PATIENT CONSENT FOR SHOCKWAVE THERAPY

WEBSTER FAMILY CARE

This document is intended to serve as confirmation of informed consent for D-Actor 50 Therapy, also known as Extracorporeal Shock Wave Therapy (ESWT).

A. PURPOSE

ESWT therapy is a non-invasive technique that uses pulsatile waves to stimulate blood flow to the applied area. ESWT is a safe procedure and has been used for a variety of health conditions.

B: BENEFITS

When applied to an area, ESWT increases blood flow, by stimulating the growth of new blood vessels (neovascularization) and growth factors thus enhancing tissue growth and repair.

C. CONSENT FOR PROCEDURE

I have received information about my condition, the proposed treatment, alternatives, and related risks. This form contains a brief summary of this information. I have received an explanation of any unfamiliar terms and have been offered the opportunity to ask questions. I understand I may refuse consent and I GIVE MY INFORMED AND VOLUNTARY CONSENT to the proposed procedures and the other matters shown below. I also consent to the performance of any additional procedures determined in the course of a procedure to be in my best interests and where delay might impair my health.

1. I authorize Dr.Siddiqi/ Webster Family Care to treat my condition, including performing further diagnosis and the procedures described below, and photographs may be recommended for medical records only.

2. I understand the purpose of the procedure(s) to be: Extracorporeal Shock Wave Therapy (ESWT) to _____ (area).

3. Although ESWT has been performed on thousands of patients and the risks are very low, we must list them. I understand the most common risks associated with the proposed procedure(s) to be: swelling, reddening of skin, soreness. Less common risks to the proposed procedure(s) to be: hematoma (bruising), petechiae (minor broken blood vessels).

4. I also understand that there may be other RISKS OR COMPLICATIONS, OR SERIOUS INJURY from both known and unknown causes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the risks of the procedure.

5. By initiating a course ESWT, your medical provider is using his or her best *judgment in* recommendations for you and there is no guarantee of an outcome.

6. I understand that if I wish not to accept the risks associated with this procedure(s), then the alternative would be to not sign this consent.

7. I have informed the practitioner of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the doctor of all current medications and supplements.

D. CONSENT FOR LOCAL ANESTHESIA

When local anesthesia and/or sedation is used by the practitioner. I consent to the administration of such local anesthetics as may be considered necessary by the practitioner in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures from lidocaine.

E. PATIENT CERTIFICATION

By signing below, I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form. I understand the information on this form and give my consent to what is described above and to what has been explained to me.

_____ / _____

SIGNATURE OF PATIENT and DATE

F. PRACTITIONER ATTESTATION

I have explained the procedure(s), alternative(s) and risks to the person or persons whose signature is affixed above. The patient has verbally communicated to me that they understand the contents of this form.

_____ / _____

SIGNATURE OF PRACTITIONER OR DESIGNEE OR DESIGNEE OBTAINING CONSENT and DATE

G. INTERPRETER ATTESTATION (when applicable)

I have provided translation to the person(s) whose signature(s) is affixed above.

_____ / _____

SIGNATURE OF INTERPRETER and DATE

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