EKLEM İÇİ, EKLEM ÇEVRESİ VE KAS ENJEKSİYONLARI İÇİN BİLGİLENDİRİLMİŞ
ONAM FORMU\_İNGİLİZCE

FOR İNTRAARTİCULAR, PERIARTICULAR AND MUSCLE INJECTIONS INFORMEDCONSENT FORM

The objective of this form is to enable your participation into the decision making process about your healthcare by informing you.

This form has been designed in order to meet the needs of many patients under most conditions, nevertheless, it should not be considered as a document containing the risk of the entire applicable treatment. Based upon your individual healthcare, your physician may provide you with different or additional Information.

After acquiring the advantages and possible risks of diagnosis, medical treatment and surgical interventions, it is up to your decision whether or not to accept these procedures. You are entitled to refuse to be informed except for the legal and medical necessities or withdraw your consent at any time.

**Information About the Procedure**

Muscles, joints and soft tissues around joints may be affected due to trauma, rheumatic and metabolic diseases, certain psychological diseases, cerebro-spinal injuries. In these cases, pain, numbness, loss of sensation and movement in the affected area, fluid accumulation in the joint, musde spasm/spasticity, complete or partial loss of strength (paralysis) in the whole body or in one area, loss of function and decrease in puality of life may occur.

Injection therapy is the application of one or more substances such as dry needle, local anesthetic, cortisone, hyaluronic acid, PRP, botulinum toxin to the appropriate area with an injector. Auxiliary methods such as EMG and ultrasound can be used if necessary during these procedures. These applications are very helpful in both diagnosis and treatment. Most of the time, it alleviates/heals complaints such as pain and limitation of movement in a shorter time, reduces unnecessary drug use, and stops the intraarticular inflammatory process. It has very few side effects and damage risk, it allovvs both fluid intake for analysis, removal of unvvanted fluid and administration of the therapeutic/supporting substance in the same session.

**Possible Risks and Compiications**

* There may be a temporary increase in pain during or after the application.
* There may be redness and swelling of the skin at the injection site.
* Periarticular injection can be possible in intraarticular applications.
* Crystal synovitis may develop in steroid-cortisone applications.
* Other possible side effects may include nausea, dizziness, low blood pressure, palpitations.
* Very rare important side effects are arrhythmia, fainting, nerve-muscle-tendon injury/rupture, allergic reactions and infection.
* During applications pneumothorax-chest air escape may occur, especially in dry needling to the back despite ali çare and attention.
* Bleeding is more likely in patients using blood thinners. The physician should be informed before the procedure accordingly.
* Risks are rarely observed when experienced medical personnel and adequate and appropriate medical equipment are available.

**Alternative Treatment Options**

Various drug and physical therapy methods, and in some cases, surgical interventions can be alternative treatment methods.

**What to Consider After the Procedure**

Excessive movements shoııld be avoided, the patient should rest well, injection site should not be touched and no other substances should be applied.

Diagnosis

Treatment/procedure to be applied

Side/grade if applicable □ Right sided □ Left sided □ Both sided Grade

Should you not intend to be informed about the purpose, duration, advantages, success ratio, potential risks and complications and alternative options of the treatment to be applied and as well as about the subsequent potential risks in case you do not accept the treatment, please declare so below with your hand writing.

I hereby declare that; My attending physician informed me about my disease, the treatment option to be applied, its duration, advantages, success ratio, the fact that it does not necessarily guarantee the recovery of current status, period of healing, potential risks and complications, alternative techniques, the potential situations I vvill experience on the condition that I reject the treatment and compulsory performance of an additional operation/intervention/procedure if deemed necessary and s/he answered ali my questions regarding these matters.

Above mentioned procedure has been disclosed to be performed on myself/patient I legally represent by the physicians, nurses as well as other healthcare professionals under the authority, surveillance and control of my attending physician.

I have been informed that if required, anesthesia vvill be performed by an anesthetist, sedation vvill be performed by an anesthetist or another physician competent in sedation and local anesthesia vvill be performed by my attending physician.

While being entitled to make decision and think straightly, I accept the medical procedure to be performed, and consent that my attending physician and his/her team vvill carry out any medical treatment option/surgical technique/intervention they deem to be necessary.

I authorize the hospital to examine, inspect, dispose of or keep the tissues or organs removed during the procedure for vvhich I have consented above. I allovv my medical reports to be used for scientific researches provided that my identifying information is kept hidden.

I understand and accept that the procedure can be performed with the attendance of a medical school student, a specialist student of medicine and a physician making clinical observation under the supervision of a chief physician in Acıbadem Mehmet Ali Aydınlar University and affiliated hospitals.

Please vvrite "I have read and understood the contents of this form" vvith your handvvriting and fiil out the belovv required fields.

|  |
| --- |
| **Patient's** |
| Full Name: | Signature: | Date: | Time: |
| Date of Birth:**Legal Representative's**Full Name:Degree of Relationship: | Signature: | Date: | Time: |
| Reason vvhy the consent is delivered by legal representative of the patient: |  |
| □ Patient is not conscious | □ Patient is under 18 | □ Other: |
| □ Patient is not entitled to make decision | □ Emergency |  |  |
| **Witness’**Full Name: | Signature: | Date: | Time: |
| **Informing Physician’s**Full Name: | Signature: | Date: | Time: |
| **Interpreter’s (If required)**Full Name: | Signature: | Date: | Time: |

informed consent is delivered by the patient himself/herself if s/he is older than 18 years old, by the patient himself/herself together vvith his/her legal representative if the patient is aged betvveen 15 and 18 and by the representative of the patient if the patient is under 15 years old and/or is unconscious and/or is not entitled to make decision and in case of emergency.