ULTRASOUND GUIDED INJECTION CONSENT FORM

Ultrasound guided procedures may be performed if requested by your referring clinician or if clinically indicated:

☐ Steroid/cortisone injection ☐ Hydro dilatation ☐ Autologous blood injection

☐ CT arthrogram ☐ Implanon removal ☐ Fine needle aspiration/biopsy

The side effects and risks of these procedures may include:

- Allergy to any of the substances utilised during the procedure, such as the cortisone, dressing, local anaesthetic or antiseptic. This is usually minor and self-limiting.

- The cortisone may result in palpitations, hot flushes, insomnia and mild mood disturbance. This usually resolves within 24 hours and no treatment is necessary.

- Infection is a rare but a serious complication. If the area becomes hot, red and sore please seek medical attention.

- Local bruising.

- Mild increase in blood sugar levels in diabetic patients for several days and may last up to a week.

- Transient increase in pain at the injection site before the cortisone takes effect. Occasionally this may be severe, however usually lasts only 24–48 hours and is treated with a cold pack, paracetamol and anti-inflammatory medication. If this occurs and you are concerned, especially if the pain is not settling despite the above treatment, then please seek medical attention.

Are you diabetic ? YES / NO (please circle)

Are you allergic to any medications ? YES / NO (please circle)

Please indicate _____

I understand the risks and benefits involved and have been given the opportunity to ask questions. I give consent to the radiologist to perform any of the above listed procedures if required.

☐ YES

☐ NO

NAME: _____ SIGNATURE:_____ DATE:___/___/___.