Patient Label

Informed Consent for Treatment/Procedure

1. I, ________________________________ , authorize ________________________________ , of Surgical Neuromonitoring Associates, Inc. and Dr. ________________________________ of Surgical Neuromonitoring, PLLC to provide the Intraoperative Neurophysiological Service requested by Dr. ________________________________ on ______________ (date).

2. I consent to the technologist performing the following Intraoperative Neurophysiological Service(s):

Somatosensory Evoked Potentials (SSEP)	☐	Brainstem Auditory Evoked Response (BAER)	☐
Motor Evoked Potentials (MEP)	☐	Train of Four (TOF)	☐
Electroneuromyography (EMG)	☐	Microvascular Doppler Sonography (MVD)	☐
Triggered Electroneuromyography (TEMG)	☐	Transcranial Doppler Sonography (TCD)	☐
Electroencephalography (EEG)	☐	Cortical Mapping (CM)	☐

   a. The Intraoperative Neurophysiological Service provided by Surgical Neuromonitoring Associates is requested on behalf of the surgeon as a preventative means of avoiding or mitigating the risks associated with surgery including, but without limitation: weakness, numbness, paralysis, pain, sexual dysfunction, loss of bowel or bladder control, nerve injury, vocal cord paralysis, facial nerve paralysis and hearing deficits.
   b. I understand that all such Intraoperative Neurophysiological Service carry risks including, but without limitation: infection, burns, hematoma, neurologic loss, device malfunction/failure, tongue lacerations, seizure, and needle breakage. I also was informed of, understand, and accept that complications from these risks and from those others mentioned above possibly can result in and cause me pain, disability and/or associated complications.
   c. I understand that there is no guarantee that the Intraoperative Neurophysiological Service provided will be successful and/or that it will resolve my medical problem and/or achieve all of its expected preventative benefits described above.
   d. I understand that I may elect to forgo Intraoperative Neurophysiological Service requested by my physician during my procedure. Should I decide to decline Intraoperative Neurophysiological Services, I acknowledge that I assume responsibility for all risks and complications associated with the absence of Intraoperative Neuromonitoring Services.

3. The technologist has discussed the following subjects with me regarding the Intraoperative Neurophysiological Service:

Content of proposed service will consist of.	☐	The material risks specific to service.	☐
The service's expected benefits.	☐	The feasible alternatives to undergoing the proposed service, and any material risks associated with these alternatives.	☐

Patient or Authorized Representative Statement and Signature

I have carefully read this form, or it has been read and explained to me. I understand the contents and implications of this form and I freely consent to all of the authorizations to which I agree herein. I had the opportunity to ask any and all questions, which have all have been answered to my satisfaction, and I understand that I may ask any further questions at any time.

Signed:

____ ____________________

Patient (If patient is a minor or unable to sign, please complete the following) Date

____

Authorized Representative

____

Relationship to Patient

Technologist Statement and Signature

I have informed the patient or his/her Authorized Representative about the nature and purpose of the Intraoperative Neurophysiological Service and about its expected benefits, material risks and feasible alternatives. The patient and/or his/her Authorized Representative informed me that he/she has read and understands all implications and conditions inherent in and to this form and I have obtained the patient's or his/her Authorized Representative's prior written consent to proceed as proposed.

Signed:

____ ____________________

Technologist Date

Printed Name:

____

Technologist Printed Name