Steroid Injection Consent Form

Please complete this form and bring it to your appointment or email it to us beforehand at office@theultrasoundclinic.co.nz

Name: ..... Date of Birth: .....

Phone: ..... Email: .....

Name and location of GP: .....

Site of Injection: ..... ACC Number: .....

Have you had a previous cortisone injection in this area? ☐ Yes ☐ No

Do you have any allergies? If so, please provide details below:

.....

Are you on warfarin or another blood thinner? ☐ Yes ☐ No

If you've had a warfarin test, what was the INR result? .....

Are you on Insulin for diabetes? ☐ Yes ☐ No

Do you have asthma? ☐ Yes ☐ No

Do you have heart or kidney conditions? ☐ Yes ☐ No

Do you have any other health conditions? If so, please provide details below:

.....

Please provide details of any medication you are taking:

.....

Have you read and understood the Steroid Injection information ☐ Yes ☐ No

Sheet that has been provided to you?

By signing this document, you are providing your consent to an Ultrasound Guided Steroid Injection

Patient Signature: ..... Date: .....

Radiologist to complete

Checklist

☐ Allergy

☐ Warfarin

☐ Insulin

☐ Complications

☐ Rehabilitation

☐ Pain relief

Treatment Provided

.....

2% Xylo 40mg: ..... ml

Kenacort 40mg: ..... ml

Marcaine 0.5%: ..... ml

Other: .....