REQUEST AND INFORMED CONSENT TO (PROCEDURE OR DIAGNOSTIC TEST)

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT'S NAME: _____DATE: _____ DOB: _____

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring this procedure is **Chronic Migraine Headache** (ICD 9: 346.71)

2. The nature of the procedure is a:Botox (64612, 64613, J0585, 95874)

3. The purpose of this procedure is TO DECREASE frequency and intensity of migraine pain (ICD 9: 346.71)

4. MATERIAL RISKS OF THIS PROCEDURE:

   As a result of this procedure being performed there may be material risk of: INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE OR CARDIAC ARREST OR DEATH.

5. In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to: INCREASED WEAKNESS OF SHOULDER AND NECK MUSCLES, DIFFICULTY SWALLOWING,EYELID DROOP,HEADACHE EXACERBATION.

6. The likelihood of success of the above procedure is:

   (x) Good ( ) Fair ( ) Poor

7. Practical alternatives to this procedure include: ORAL MEDICATIONS.

8. If I choose not to have the above procedure, my prognosis (future medical condition) is:FAIR.

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which as been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of the procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

I also consent to diagnostic studies, anesthesia, x-ray examinations and any other treatment or course of treatment relating to the diagnosis or procedures described herein.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS AND STATEMENTS REQUIRING

COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRIKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. Alison Drake-Barrack and any other physicians or other medical personnel who may be involved in the course of my treatment.

_____ _____

Witness Person giving consent

_____ _____

Physician Relationship to patient if not the patient

Patient unable to sign because of_____

_____

Additional material used, if any, during the informed consent process for this procedure include:

_____

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