MORGANTOWN DENTAL GROUP
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REQUEST AND INFORMED CONSENT FOR PHLEBOTOMY

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS!

Patient's Name: _____ Date: _____

The following has been explained to me in layman's terms and I understand that:

1. The patient's diagnosis and procedure(s) or treatment(s) are**: Therapeutic Phlebotomy or removal of blood.**
2. The material risks of this procedure or treatment may include but are not limited to: risk of infection or bleeding, allergic reaction, nausea, vomiting, lowered blood cell counts which may cause anemia, vein irritation, dizziness, decreased blood pressure, diaphoresis (clammy skin), pain or bleeding at site, redness,fatigue,cardiac arrest, which can result in life threatening changes.

Information for this procedure was provided through written and verbal communication.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCE HAVE BEEN MADE TO ME concerning the results of these procedure(s) or treatment(s).

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

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

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ OR HAD IT READ OR EXPLAINED TO ME AND I UNDERSTAND THIS FORM. I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED SATISFACTORILY. I VOLUNTARILY CONSENT TO DR. JOSH DOLIN OR ANY PHYSICIAN DESIGNATED OR SELECTED BY HIM OR HER AND ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIAN AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN PERFROMING SUCH PROCEDURES TO PERFORM THE PROCEDURES DESCRIBE OR OTHERWISE REFERRED TO HEREIN.

_____ _____
Patient Printed Name Patient Signature

_____ _____
Printed Name of Legally Authorized Representative Relationship to Patient

_____ _____
Signature of Doctor Date