

# Neurology Evaluation Consent Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient ID: \_\_\_\_\_

## Procedure Information

You are being asked to consent to the following procedure(s):

- Neurological evaluation
- Neuroimaging (if applicable)
- Electroencephalogram (EEG) (if applicable)

## Purpose of the Procedure

The purpose of these procedures is to diagnose and evaluate neurological conditions that may affect your health.

## Risks and Benefits

While these procedures are generally safe, potential risks include:

- Discomfort or pain during the procedure
- Allergic reactions to contrast dye (if applicable)
- Rarely, complications related to sedation (if applicable)

Benefits of the procedure include a clearer understanding of your neurological health and appropriate treatment options.

## Consent Statement

I, the undersigned, have read and understood the information provided regarding the neurological evaluation and related procedures. I have had the opportunity to ask questions and have received satisfactory answers. I consent to undergo the mentioned procedures.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

## **Contact Information**

If you have any questions or concerns, please contact:

Neurology Department Phone: \_\_\_\_\_

Email: \_\_\_\_\_