

# Extracorporeal Shockwave Therapy Patient Consent Form

## Qualifying for ESWT (Extracorporeal Shock Wave Therapy)

By answering the following questions, you will assist us to decide if you are a good candidate for ESWT.

- Have you been injected with cortisone within the past 4 weeks? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer / tumor? Yes / No
- Do you have a skin infection? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

## RISK OF THIS PROCEDURE

- A) Temporary soreness.
- B) The FDA has labeled this a Class I Device therapy, which is generally considered a "non-significant risk" when used as intended.

## Consent for Procedure

I, \_\_\_\_\_, the Undersigned, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of

\_\_\_\_\_.

I have been fully informed of ESWT which the use of has been fully explained to me by my treating physician/ staff, and I fully understand the nature of this treatment. I confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me as to the level of effectiveness. I also understand foregoing ESWT treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

Signed \_\_\_\_\_

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