FAKULTNÍ NEMOCNICE OLOMOUC
Zdravotníků 248/7, 779 00 Olomouc
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Company ID: 00098892

Patient's/legal representative's informed consent to lumbar puncture

Patient – name and surname:	Birth registration number (insurance number):
Date of birth: (if no birth certificate number exists)	Insurance company code:
Patient's permanent address: (or other address)	
Name of legal representative (guardian):	Birth certificate number

Name of the procedure

Acquisition of cerebrospinal fluid

Purpose of the procedure

The aim of this procedure is the examination of the fluid circulating around the brain and the spinal cord. This examination enables us to rule out the affection of the central nervous system by inflammation, bleeding or cancer.

Nature of the procedure

The procedure is performed in sitting position or when lying down. A special hollow needle with an inserted removable cap (stylet) is utilised. The needle is inserted between the arches of two adjacent lumbar vertebrae. This way, the needle reaches the spinal canal space at the level where there is no risk of damage to the spinal structures. After the stylet is pulled out of the needle, the necessary amount of cerebrospinal fluid for subsequent processing is collected. The hollow needle may be used to measure the pressure of the cerebrospinal fluid with a manometer or to administer special drugs directly into the spinal canal.

Expected benefit from the procedure

Ruling out of inflammatory, vascular affection, cancer or neurodegenerative damage to the central nervous system.

Alternatives to the procedure

Brain and spinal cord imaging using computed tomography or magnetic resonance imaging cannot reliably rule out incipient inflammation of neural structures and is not able to examine the specific markers (indicators) important in many affections of the brain and spinal cord.

Potential risks of the procedure

The entire area where the needle is to be inserted is disinfected. A disposable needle is used, so there is no risk of infection into the spinal canal.

The risk of brain tissue incarceration due to substantially increased intracranial pressure is ruled out based on the previous brain imaging or eye fundus examination.

A small bruise may form at the insertion site.

Please inform the attending physician of the use of drugs affecting blood clotting (Warfarin, Lawarin) to reduce further risk associated with the procedure.

Consequences of the procedure

We recommend that patients lie in a horizontal position for at least 12 hours, preferably 24 hours after the procedure. Adequate fluid intake is required. Dull headache with dizziness, nausea or vomiting may develop due to the removal of cerebrospinal fluid.

Consent:

Note: circle your answer:

I have been clearly informed about alternatives to the procedures performed at the University Hospital Olomouc, which I can choose.	YES	NO
I have been informed about the possible limitations of the usual way of life and work capacity after the respective medical procedure, and also about changes to health capability in the event of potential or anticipated health changes.	YES	NO
I have been informed about the treatment regimen and suitable preventive measures, and about control medical procedures.	YES	NO
I understand all the explanations and information, which I received from the doctor, and I have had the opportunity to ask additional questions, which were answered by the doctor.	YES	NO

After receiving the above explanations, I hereby declare:		
- that I consent to the proposed care and performance of the procedure and, in the event of unexpected complications, to the urgent performance of additional procedures, necessary to save a life or health.	YES	NO
- that I have been honest with my doctors and have provided them with all the information about my health, which was known to me and which could adversely affect my treatment or put anyone else at risk, in particular by the spread of communicable diseases.	YES	NO
- that if necessary, I consent to the sampling of biological material (blood, urine...) for necessary tests to rule out in particular, communicable diseases.	YES	NO

Date	**Hour**	**Patient's / Legal representative's (guardian's) signature**

Name and surname of the doctor who provided the information	**Signature of the doctor who** provided the information

If the patient is unable to sign, specify the reasons for which the patient was unable to sign:			
How the patient expressed his/her will:			
Name and surname of the healthcare professional/witness	**Signature of the healthcare professional/witness**	**Date**	**Hour**