**CONSENT FOR TRIGGER POINT INJECTIONS**

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

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do hereby authorize Dr, Wayne Phimister and the staff at Newleaf Total Wellness Centre to carry out all examinations, diagnostic procedures and treatments and to administer all medications deemed necessary that relate to trigger Point Injections.
2. The purpose, nature and risks and benefits of the foregoing procedure(s), as well as available alternatives and the consequences of not having treatment, have been explained to me by the doctor named above to my satisfaction.
3. I agree that the doctor named above may use the help of other doctors, medical residents, authorized students and clinic staff as he considers appropriate.
4. I understand that Newleaf Total Wellness Centre may be involved in medical teaching and that authorized medical students may be involved in or observe my care.
5. For the health and safety of healthcare providers, I agree to testing for Hepatitis B & C and/or HIV if a staff member is exposed to my blood or body fluids during my treatment. I understand that the results of these blood tests will be shared with me and my physician. I am aware that certain infectious diseases must be reported to the regional Medical Health Officer who may trace contacts as permitted by legislation.

I agree that I have read and fully understand the above consent, that I have had the opportunity to ask questions and that the explanations referred to in this document were made.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_ at\_\_\_\_\_\_hrs

(Patient or person legally authorized to give consent)

Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (If Not Patient) (Relationship to Patient if not Patient)

Witness signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_