DONALD A. SAMPLE, M.D.
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Big City, USA 92673
TEL: 555-555-1212
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CONSENT FOR A
Physical medicine treatment

I am aware and my family has been informed of the diagnosis of my condition and the recommended treatment.

I and my family request this attending physician to perform the treatment indicated below on me.

I and my family have been advised and are aware of the risks and possible complications of this treatment which include, but are not limited to, failure of the procedure to eliminate the pain, headaches, muscle cramping, itching, skin burns, (possible blistering), at site of application, nausea, vomiting and, in women, the possibility of temporary change in the menstrual cycle.

I hereby request that Dr. _____ to

perform **Physical Medicine Treatment.**

Date: _____ _____
Patient Signature

_____ _____
PATIENT NAME ID#

_____
Witness

_____
Physicians Signature