Consent for Anti-Smoking Treatment

I, ________________________ have requested that Dr. Kochan treat me for nicotine addiction.

I understand that although this treatment has been used in many clinics it is not yet accepted as a "traditional" treatment by many physicians and is considered experimental.

I understand that this treatment consist of a series of three injections over a thirty minute period of time using three standard medications, and as with any invasive procedure there are associated risks.

The most common side effects are dry mouth, blurred vision, fatigue and drowsiness for up to 24 hours. Other possible side effects, although unlikely, include disorientation, memory disturbances, dizziness, restlessness, confusion and hypotension.
Dr. Kochan has explained the possible risks and common side effects of this treatment in addition to the inherent dangers associated with cigarette smoking.

I certify that I have read and, and fully understand, the above paragraphs, and that I have had sufficient opportunity to ask questions.
I also certify that I have given a complete and honest history of all medications and medical conditions.

Patient Signature_____________________________ Date___________