Spine and Pain Centers Patient Name:_____DOB:_____

Informed Consent for Procedure

You have a pain problem that has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatment of your pain. There is **no guarantee** that a procedure will cure your pain, and in rare cases, it could become worse, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, then determine if further treatment is necessary.

Your physician will explain the details of the procedure listed below. **Tell the physicians if you are taking any blood thinners such as Coumadin, Lovenox or heparin,** as these can cause excessive bleeding and a procedure should not be performed.

Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc.

Benefits include increased likelihood of correct diagnosis and /or of decrease or elimination of pain.

Risks include infection, bleeding, allergic reaction, increased pain; nerve damage involving temporary or permanent pain, numbness, weakness, paralysis or death; air in lung requiring chest tube; tissue, bone or eye damage from steroids. Nerve destruction with phenol, Botox, alcohol, or radiofrequency energy has risks of nerve and tissue damage.

Specific risks pertaining to each specific procedure are as follows (patient to initial line of procedure):

_____ **Epidural/Facet Joint, Medial Branch Nerve, Sacroiliac Joint, Selective Nerve Root or Lumbar Sympathetic Injection/Block/Ablation:** Low blood pressure, temporary weak/numb arm or leg, headache requiring epidural blood patch.

_____ **Epidural or Spinal Opioid Injection:** Itching, nausea, urinary difficulty, slowed breathing.

_____ **Discogram, Nucleoplasty, Nucleotome, Decompressor, Endoscopic Discetomy or IntraDiscal Electrothermal Therapy (IDET):** Infection or discitis.

_____ **Stellate Ganglion Block/Ablation:** Hoarseness, difficulty swallowing, seizure, weak and/or numb arm, air in lung.

_____ **Trigger Point Injection, Peripheral Nerve-Neuroma Block, Occipital Nerve Block, Intercostal Nerve Block/Ablation:** Air in lung requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin.

_____ **Radio Frequency Denervation:** Nerve damage

_____ **Spinal Cord Stimulator Im/Explant, Spinal Infusion Pump Im/Explant or Refill, Epidural or Spinal Catheter Im/Explantation:** Infection requiring hospitalization and removal of stimulator, catheter or pump; meningitis, nerve damage.

_____ **Joint Injection (Hip, Shoulder, Knee, Elbow, ect..):** Bleeding, infection, allergic reaction, nerve damage, increased pain.

The incidence of serious complications listed above requiring treatment is low. Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done.

I have read or had read to me the above information including the Pre-Procedure Patient Instruction page. **I understand there are risks involved with spinal procedure, to include rare complications, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to any procedure.**

I also understand that one of the greatest risks involved with pain management procedures involves various medications taken, allergies and my general medical condition. I will inform the doctor of any blood thinning medication taken or any changes in other medications, allegeries or medical condition prior to any procedure.

_____ _____ _____
Patient or his/her legal guardian Date Witness

Physician Declaration: I and/or my assistant have explained the procedure and the pertinent contents of this document to the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed and the patient has consented to the above described procedure.

_____ _____
Physician Date