

INFORMED CONSENT FOR SPINAL OR JOINT INJECTION

The injection involves placing a small needle in or around the painful area injecting a numbing medication and anti-inflammatory medication (steroid or other type of solution). If the injection is for diagnostic purposes only, anesthetic or contrast dye will be used. This injection will hopefully give you significant pain relief and give us important information that will enable us to diagnose you condition.

Some injection procedures involve the use of radiofrequency energy to interrupt nerve transmission by lesioning or shocking of specific nerves.

Dr. _____ and/or and associate has explained the nature and purpose of this procedure and has answered my questions. I do understand that this is considered an elective procedure. I understand my current condition for which I am having the procedure is not life threatening.

Possible side effects associated with this procedure include:

1. Regional numbness, weakness and/or dizziness. You may have increased numbness for one-hour to six hours after the block. We advised you not to operate a vehicle or perform any activities that require coordination for six to ten hours after the block.
2. Vasovagal reactions (fainting) could occur during or after the procedure with possible heart and blood pressure problems.
3. Reactions to medication include minor or temporary allergic reaction and/or a temporary decrease in blood pressure. These problems may require more aggressive treatment including IV or other medications
4. Increased pain. Twenty percent of patients may have increased pain for one to seven days after the injection.
5. Less than one percent of patients may have a headache after the procedure. Treatment of the headache may necessitate additional procedures and/or hospitalization.
6. Infection either around the injection site or deep in the spine is also a potential risk. Other rare complications might include hip (bone) damage caused by steroids, temporary or permanent nerve impairment, bleeding, bruising, seizures, stroke, paralysis, collapsed lung, bowel/bladder/sexual dysfunction and death.

If the block is performed specifically for diagnostic purposed, a steroid may not be used. If this is the case, complications or side effects associated with steroid use will not be a possibility.

I have discussed treatment alternatives with Dr. _____ including no treatment.

I _____ consent to this procedure to be preformed by

Dr. _____ and/or his associate.

As requested by my physician I am aware that I am NOT to drive myself home or operate a vehicle for six to ten hours.

Name of procedure**: _____ **(For Provider Use Only)

Patient Signature

Date

Physician Signature

Date

Witness Signature

Date

Time out process performed prior to procedure _____
Procedure room Tech/MA Signature