CHIPPEWA VALLEY ORTHOPEDICS AND SPORTS MEDICINE
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CONSENT FOR PAIN MANAGEMENT PROCEDURE

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

Your physician will explain the details of the procedure listed below. Tell your physician if you're a taking any blood thinner such as Coumadin, Lovenox, Plavix, Heparin, Brilinta, Xarelto, or Eliquis, as these can cause excessive bleeding and may need to be stopped prior to the procedure.

Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc. Benefits include increased likelihood of correct diagnosis, elimination of your pain or decrease in the severity of your 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, and tissue, bone or eye damage from steroids. Nerve destruction with radio-frequency energy has risks of nerve and tissue damage.

Specific risks pertaining to each specific procedure are as follows:
_____**Epidural, Medial Branch Nerve, Lumbar Sympathetic/Block, Radiofrequency Ablation**: Low blood pressure, temporary weakness/numbness arm or leg, headache requiring epidural blood patch, meningitis, infection, paralysis.
_____**Spinal Cord Stimulator Trial**: Infection requiring hospitalization and removal of stimulator, meningitis, nerve damage.
_____**Intra-articular Hip Injection**: Nerve damage, infection, loss of motion.
_____**Sacroiliac Joint:** Infection, loss of motion, bleeding, allergic reaction.

The incidence of serious complications listed above requiring treatment is very low (less than 1% in our experience). Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you. It is your decision and right to accept or decline to have the procedure done.

I authorize Dr. Carol Sue Carlson to perform the following procedure:

_____.

I have read or have had read to me the above information, I understand there are risks involved with this procedure, including rare complications, even death, which may not have been specifically mentioned above. I understand that a sedative may be administered for my comfort during the procedure and that sedatives carry the risk of damage to vital organs, such as the brain, heart, and lungs. The risks have been explained to my satisfaction and I accept them and consent to this 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

For office use only:

□ 1st □ 2nd □ 3rd

□ Diagnostic

□ Confirmatory

Patient Name: _____

Patient DOB: _____

□ Office Visit □ Video Call □ Phone Call
F/u Date: _____ @ _____