Informed Consent for Pain Procedures

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 **PLAVIX, Aspirin, 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 are

- **Increased pain and allergic reaction** from local anesthetics, iodine, contrast (X-Ray dye), materials containing latex, IV anesthetics and/or other medications
- **Allergic reaction from steroid;** facial flushing, elevation in blood glucose, headache, increased appetite, weight gain, swelling, menstrual irregularities, hoarseness, numbness, infection, abnormal heartbeats, increased blood pressure, stroke, heart attack, insomnia, ect.
- **Infection** on skin, tissue, bones, joints, discs, nerves, ligaments, possibly blood stream (Sepsis), brain and spinal cord (Meningitis) may require hospitalization
- **Bleeding** into epidural space (Epidural Hematoma) and into spinal canal (Spinal Hematoma) may require surgical interventions such as an evacuation of blood from epidural space or spinal canal and decompression surgery
- **Nerve damage, nerve injury, tissue injury, tissue damage, temporary and permanent numbness and/or weakness, paralysis, spinal cord injury, urinary and/or fecal incontinence**
- **Headache** ("Spinal headache") may require blood patch (Injecting your own blood into epidural space) and hospitalization
- **Death**
- **Stellate Ganglion Block**: In addition to the above complications, hoarseness, difficulty swallowing, seizure, air in lung requiring a chest tube in the hospital
- **Trigger Point Injection, Peripheral Nerve block, Occipital Nerve Block:** In addition to the above complications, **air in lung (Pneumothorax)** requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin.
- **Joint injection:** In addition to the above complications, **injection and fluid collection in the joint(s)** may require antibiotic treatment, fluid aspiration and surgical interventions.

Procedure: ____

The incidence of serious complications listed above requiring treatment is low, but it may still occur. 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 which is performed by **Dr. Young Lee, Dr. U. Purewal, Dr. M. Purewal, Dr. Ezeadichie, Dr. Rinnier, Dr. Manabat, Dr. Puri, Dr. Reyes, Dr. Pryzbylkowski, Dr. Park, Dr. Jalali, Dr. Varghese and/or their associates in Relievus, LLC**. I herein authorize physicians, nurse practitioners and their associates in Relievus, LLC to perform this 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, allergies or medical condition prior to any procedure.

X ______________________________________ ________________ X ______________________

Patient or his/her legal guardian Date Witness

Medical Provider Declaration: I and/or my associate 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.

______________________________________ X ______________________ ________________

Medical Provider's Name Medical Provider's Signature Date