

NJ Spine and Pain Center Inc  
(609) 587-6070

## PROCEDURE CONSENT

### FORM

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

#### Informed Consent for \_\_\_\_\_

**at NJ Spine and Pain Center Inc** 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 physician if you are taking any blood thinners such as Coumadin, Lovenox, Heparin, Plavix, Warfarin,** 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, alcohol, or radiofrequency energy has risks of nerve and tissue damage. **Specific risks** pertaining to each specific procedure are as follows:

**Epidural/Facet Joint, Sacroiliac Joint:** Low blood pressure, temporary weak/numb arm or leg, headache requiring epidural blood patch, itching, nausea, urinary difficulty, slowed breathing, small pimple like rash.

**Discogram, Nucleoplasty, Nucleotome, Decompressor or IntraDiscal Electrothermal Therapy**  
infection or discitis.

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

**Trigger Point Injection, Joint Injection, Occipital Nerve Block, Intercostal Nerve Block/Ablation: Aii**  
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 Implant/Explant or Refill:**  
Infection

requiring hospitalization and removal of stimulator, catheter or pump; meningitis, nerve damage.

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, allergies 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 \_\_\_\_\_

\_\_\_\_\_