Atlantic Spine&Pain

1031 West Williams Street, Suite 102, Apex, NC 27502
Phone (919) 439-7867Fax (919) 573-9594

INFORMED CONSENT FOR PROCEDURES

Name: _____Date of Birth_____
Procedure: _____Date_____

The purpose of the procedure is to relieve pain and/or assist in diagnosing the source of your pain. This involves injecting one or more of the following substances: anesthetic (numbing agent), contrast material (to confirm needle placement), corticosteroid, saline and/or dextrose. Possible side effects/complications include, but are not limited to the following: headache, allergic reaction, flushing, low grade fever, change in blood pressure, dizziness, fainting, anxiety, depression, insomnia, confusion, drowsiness, blurred vision, tremor, tingling, numbness, weakness, loss of coordination, bladder or bowel changes, ringing in the ears, elevated blood sugar, nausea, vomiting, rash, swelling, nerve/brain damage, seizures, blood clot or bleeding, infection, inadvertent dural puncture (spinal tap), pneumothorax (punctured lung), avascular necrosis, scarring around the spinal cord, skin healing problems at injection site, and death.

With Radiofrequency Ablation, there may be itching, burning, and sensitivity of the skin on the back or neck which usually resolves in 4-6 weeks.

Patients may also experience a temporary increase in pain which usually resolves in 1-5 days, but may persist, especially in persons with chronic pain prior to the procedure. Side effects/complications are usually temporary, but may persist.

Patients on blood thinners may require medical clearance from the doctor who prescribes the medication. If your doctor allows you to temporarily stop taking your blood thinner, you may be at risk for increased problems related to your medical condition (stroke, heart attack, blood clots).

Please answer the following questions to ensure your safety:

Are you on blood thinners? Yes No
If Yes, which one(s)? _____
The date of your last dose was on_____
Are you allergic to shellfish? Yes No
If Yes, what type of reaction? _____
Are you allergic to contrast dye? Yes No
If Yes, what type of reaction? _____
Are you allergic to anesthetics (Lidocaine/Novocain/Marcaine)? Yes No
Are you allergic to Latex? Yes No
If female, are you pregnant? Yes No

I, being of sound mind, consent to the procedure and acknowledge all statements above.

Patient signature_____Date:_____
Physician signature_____Date:_____
Witness signature_____Date:_____