Maryland Pain & Wellness Center
RESTORING HOPE, REBUILDING LIVES

MARY LAND PAIN & WELLNESS CENTER, P.A.
CONSENT FOR PROCEDURE FORM

PATIENT _____

DATE _____ TIME _____ A.M/P.M

1. I authorize Dr. Achampong/an associate of Dr. Achampong to treat the following condition (s):

_____

(Description of condition, need for treatment and expected outcome.)

2. My physician, Dr. Achampong/an associate of Dr. Achampong, has explained the procedure necessary to treat my condition as follows:

Epidural Steroid Injection

Cervical_____ Thoracic _____ Lumbar _____ Transforaminal _____ Caudal _____

Selective Nerve Root	Level (s) _____	R	L
Medial Branch Block	Level (s) _____	R	L
Radiofrequency Ablation	Level (s) _____	R	L
S I Joint		R	L

Sympathetic Blocks:	**R**	**L**
Stellate		
Celiac Plexus		
Splanchnic		
Hypogastric		
Sympathetic Block Lumbar		
Ganglion of Impar		

Spinal Cord Stimulation: Occipital Cervical Thoracic Lumbar Peripheral

Other_____

3. I understand that possible risks such as severe blood loss, infection and cardiac arrest may occur in any surgical procedure. My physician has explained the additional risks associated with this procedure. These risks include but not limited to: infection, variable pain relief, hematoma, headache, paresthesia, allergic reaction, nerve damage, bleeding, pain at injection site,
_____.

4. I understand that during the course of the operation, unforeseen conditions may become apparent which require and extension of the original procedure or a different procedure. I authorized my physician, his associates or assistants to perform such procedures as they, in the exercise of their professional judgment, deem necessary and advisable.

5. I consent to the administration of anesthetics. I understand that an anesthesiologist will direct my anesthesia care unless an anesthesiologist is not required because of the type of procedure or the medication to be used. In that event, my physician will direct the sedation and/or pain control, and has discussed the method to be used, as well as any risks, benefits and alternatives.

6. All information concerning this procedure and necessary for my informed consent, including alternative forms of treatment, has been disclosed to me. Also, all my questions about the procedure have been answered.

7. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me about the results of this procedure.

8. I consent to the photographing or televising of the operation or procedure to be performed, including appropriate portions of my/the patient's body, for medical, scientific or educational purposes as long as my/the patient's identity is not disclosed.

Patient's Signature_____

Date_____

Witness's Signature_____

Date_____