Florida Pain Medicine / Dr. Bhalani
Wesley Chapel / Brandon Office

Local - PO Sedation Forms

****Originals****
Please make copies for use.

FLORIDA PAIN MEDICINE
Restore Function Relive Life
INTERVENTIONAL SPINE & PAIN MANAGEMENT

Consent for Procedure

You have both the right and responsibility to make decisions concerning your healthcare. The physician shall provide you with the necessary information, but, as a member of the healthcare team, it is essential that you enter into the decision-making process. This form has been designed to document your informed consent to the procedure(s) that you have discussed with your physician.

1. I ______________________________________, Date of Birth ________________, hereby authorize ☐ Dr. Maulik Bhalani ☐ Dr. Arpit Patel ☐ Dr. Stephanie Epting ❑ Dr. Bryan Thomas ☐ Dr. Srinivasan Sathya ❑ Dr. Shawn Murphy ❑ Dr. Maria Cristancho and / or such associates and / or assistants as may be selected by said physician to perform the below procedures(s).

☐ Cervical	☐Epidural Steroid Injection	☐Trigger Point Injection
☐ Thoracic	☐Transforaminal Steroid Epidural Injection	☐Stellate Ganglion Block
☐ Lumbar		☐Interlaminar Epidural Steroid Injection
☐ Caudal	☐Medial Branch Block/ Facet Block	☐Sympathetic Lumbar Nerve Block*
☐ Hip	☐Radio Frequency Ablation	☐Intercostal Nerve Block Injection
☐ Greater Trochanter	☐Genitofemoral Nerve Block	☐Ganglion Impar
☐ Knee	☐Sacroiliac Joint Injection	☐Ilioinguinal Nerve Block
☐ Shoulder	☐Cluneal Nerve Injection	☐Piriformis Block
	☐Intra articular Nerve Block	☐Subacromial Bursa Block
☐ Right ☐ Left	☐Carpal Tunnel Injection	☐Ulnar Nerve Injection*
☐ Bilateral	☐Kyphoplasty	☐Spinal Cord Stimulator Trial
	☐Greater Trochanter Bursa Injection	☐Genicular Nerve Block
	☐Vertebroplasty	☐Discogram*
	Low frequency of use (expendable if needed)	

☐ Cervical 3rd Occipital Nerve C3, C4, C5, C6, C7
☐ Thoracic T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12
☐ Lumbar L1, L2, L3, L4, L5
☐ Sacral S1, S2, S3, S4, S5

CPT Code: ________________________________ Modifier:__________________________
____

2. Anesthesia: I authorize my physician to administer local anesthesia with possible oral sedation. I hereby authorize a RN to administer the anesthetic drug for my procedure under the direct supervision of my physician.

Type of Anesthesia: ☐ N/A

CONSCIOUS SEDATION (Level II) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Expected Results: Reduced anxiety and pain, partial or total amnesia.

Technique: Drug injected into the bloodstream or by other routes producing a semi-conscious state.

Risks: These may include, but are not limited to; swelling, bleeding or discomfort at the site of injection; phlebitis or other damage to blood vessels; nerve damage; allergic reactions to the anesthetic agents; memory dysfunction/memory loss; nausea and vomiting; dental trauma including but not limited to broken/loose teeth; and prolonged recovery from anesthesia. There is also a rare potential for serious harm, including difficulty breathing, permanent organ damage, cardiac arrest and death.

☐ Dr. Epting's patients will only receive local anesthesia by Dr. Epting.

Initials: ______________

3. I authorize the physician, and / or associate, to perform such extension of the procedures(s) described above that they, in the exercise of their professional judgment, determine to be necessary in the event other conditions become apparent during anesthesia, sedation, or during the procedure(s) specifically authorized above. This authority includes treating conditions whether or not they were previously known or foreseen.

4. In discussion with the above-named physician and / or associate, I have been informed of and understand:
(A) the benefits, risks and complications of this specific procedure(s).
(B) that there are significant risks such as severe loss of blood, infection, perforation/tear, and cardiac arrest which may result from the performance of any procedure(s), and in some cases, may lead to partial or permanent disability or death. Additional risks may include, but not limited to bleeding, infection, increased pain, headache, damage to nerves, seizures, stroke, paralysis, arachnoiditis, other organ system complications, other unforeseen circumstance, or even death.
Specific risks pertaining to each specific procedure are as follows, but not limited to:

- Epidural, Facet, Joint, Medial Branch Nerve, Sacroiliac Joint, Selective Nerve Root or Lumbar Sympathetic Injection/Block/Ablation: Low blood pressure, temporary weakness/numbness arm or leg, headache requiring epidural blood
- patch, meningitis, infection, paralysis.
- Epidural or Spinal Opioid Injection: Itching, nausea, urinary difficulty, slowed breathing.
- Discogram, Intradiscal Steroid Injection or IntraDiscal Electro Thermal Therapy (IDET): Infection or discitis, nerve injury, leg weakness, leg pain, paralysis.
- Stellate Ganglion Block/Ablation: Hoarseness, difficulty swallowing, seizure, weak and/or numb arm, air in lung requiring a surgical chest tube, Infection.
- Trigger point injection, Peripheral Nerve-Neuroma Block, Occipital Nerve Block, Intercostal Nerve Block/Ablation: Air in lung requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin, pneumonia, chronic pain.
- Celiac or Superior Hypogastric Plexus Block/Ablation: Low blood pressure, internal vessel/organ puncture requiring emergency surgical treatment to repair it, temporary or permanent bowel, bladder, or sexual dysfunction
- Spinal Cord Stimulator implant/explant, Spinal Infusion Pump implant or explant or Refill, Epidural or Spinal Catheter implantation or explantation: Infection requiring hospitalization and removal of stimulator, catheter or pump, meningitis, nerve damage.
- Percutaneous Lysis of Epidural Adhesions: Nerve damage, meningitis, dural puncture, eye hemorrhage, chronic leg weakness.
- Myobloc/Botox (Botulinum Toxin) Injections: Nerve or tissue damage, prolonged neuromuscular weakness.
- Intra-articular Injection: Nerve damage, infection, loss of motion, avascular necrosis

Initials: _______________

(C) Possible side effects of the medication, agents, and procedures may include, but are not limited to the following: headache, flushing, low grade fever, temporary decrease in blood pressure, dizziness, fainting, anxiety, mood swings, insomnia, confusion, euphoria, blurred vision, tremor, tingling, numbness, weakness, difficulty urinating or defecating, incontinence, drowsiness, ringing in the ears, elevated blood sugar, elevated blood pressure (more common in patients with diabetes or hypertension), nausea, vomiting, rash, itching, swelling, abdominal pain, worsening of reflux and stomach ulcers, worsening of Crohn's disease and ulcerative colitis, worsening of osteoporosis,, worsening of congestive heart failure, menstrual irregularities, transient worsening of depression, loss of skin pigment and atrophy at needle insertion site, infection or worsening of preexisting infection, worsening of kidney function in those with kidney problems such as renal insufficiency, loss of coordination, strength, sensation and mobility which would interfere with self-care (which would be detrimental to walking, driving, etc.), which would require you to arrange for assistance as needed. If you need assistance, it is your responsibility to arrange it, and you should not drive until you are fully independent. If any of the above mentioned side effects occur, they are usually temporary or short-lived, but may be persistent. Patients may also experience a temporary increase in pain or discomfort which may be from either the needle stick itself, or from the injected medication or contrast. This often resolves in 1-5 days, but may persist. A small minority of patients (even without the recognized complications discussed) may perceive increased pain that persists without a good explanation or reason. This is more likely (but still uncommon) to occur in persons with chronic pain before the injection.

(D) that no guarantee has been made to me as to result or cure or pain relief.

(E) medically acceptable alternative / therapies and the benefits, risks, and complications of those alternatives or therapies.

(F) that I have the right to refuse the recommended procedure(s), the options available to me if I refuse to consent, and the expected consequences of such a refusal.

(G) the risk and benefits of <u>not having</u> the procedure/treatment done.

5. I acknowledge that, among those who attend to patients at Florida Pain Medicine are students and other observers, and they may be present during the medical or surgical procedure(s) for educational purposes.

6. I authorize the physician/provider and Florida Pain Medicine to photograph / videotape my procedure(s)at his or her discretion. I understand the photograph(s) / videotape will be used only for the purposes of medical study, research and for documentation for the medical record but my name and identity will not be disclosed.

7. I consent to the administration of anesthesia / sedation / pain relief medications by the physician, and anesthesia provider, RN, or other qualified party under the direction of a physician, as may be deemed necessary. I understand that all anesthetics / pain relief medications involve risks of complication and possible damage to vital organs or death.

8. If necessary, Anesthesia care (Conscious IV Sedation) for this surgical procedure will be provided by a team consisting of Physician Anesthesiologists, Certified Registered Nurse Anesthetists or Registered Nurses with special anesthesia training (the Anesthesia Care Team). I understand that the members of the Anesthesia Care Team may or may not be employees or agents of Florida Pain Medicine. This anesthetic plan may include IV conscious sedation.

9. I disclosed my health history accurately on the New Patient history form while also providing any changes or updates to my health history with my provider during subsequent follow up office visits. I consent to sharing this information with the health care facility where the injection will be done, my referring doctor, and insurers

Initials: ___________

for the purposes of payment. I agree to the sharing of information I voluntarily disclose on diseases including but not limited to HIV, AIDS, hepatitis, and my history of drug, alcohol or substance abuse if any.

10. In the event of accidental exposure of my blood or body fluids to physician or staff, I consent to oral / blood testing for HIV and hepatitis B / C.
11. **(Female Patients Only)** I am not pregnant. I understand that there is a risk to the fetus if I undergo the injection and with the use of fluoroscopy if I do not know I am pregnant. If I am unsure about possible pregnancy, I will see a doctor to confirm that I am not pregnant before proceeding. I will let Florida Pain Medicine know immediately if I am pregnant or think I may be pregnant prior to any treatment or procedure.

Initials: _____________

12. I agree to notify my physician immediately if I am taking a blood thinner such as, but not limited to, Coumadin/Warfarin, Plavix, Xarelto, Aggrenox, Lovenox, Heparin, Aspirin, or other blood thinning medications. If I am on these or other blood thinning medications, I may need clearance to stop these types of medicine from my primary care doctor or prescribing physicians for these medicines, and stopping them does increase the risk to my overall health and well being which was explained to me by the doctor providing clearance. By not stopping these blood thinning medicines, there is an increase risk of bleeding and more severe complications and certain procedures may not be performed by the physician upon their discretion.

Initials:_____________

13. I have received and reviewed the pre-procedure instruction sheet. It was thoroughly explained to me and I agree to follow all instructions. I will immediately alert the office of Florida Pain Medicine prior to the procedure if my health status changes or there are any changes in my prescribed medication from any physician.
14. I, being of sound mind, consent to the procedure and acknowledge all statements above. I agree that this consent form shall be valid for any date this procedure is scheduled.

☐ This consent has been translated to me in __________________. I, the patient, have had the opportunity to ask questions and wish to proceed with the planned procedure. Translator's Name (Print):_________________________ **Pt. Initials:___**

I have read and fully understand this form, and understand that I should not sign this form if all items, including my questions, have not been answered to my satisfaction or I do not understand any of the terms or words contained in this consent form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PROVIDER NOW, BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM UNLESS YOU HAVE READ AND THOUROUGHLY UNDERSTAND THIS FORM.

This Facility is regulated pursuant to the rule of Board of Medicine of the State of Florida as set forth in the rule chapter 64B8 & 64B15, F.A.C

Patient/Party Responsible Signature: __________________________________ Date: _________ Time: _________

Witness: ____ Date: _________ Time: _________

PROVIDER DECLARATION: I have explained the contents of the document to the patient and have answered all the patient's questions. To the best of my knowledge, I feel the patient has been adequately informed and has consented.

Physician's Signature: ____ Date: __________ Form date: 11/27/19

FLORIDA PAIN MEDICINE

INTERVENTIONAL PAIN PROCEDURE PRE-OPERATIVE INSTRUCTIONS

❑ LOCAL ❑ ORAL SEDATION ❑ IV SEDATION

Patient Name:____**DOS:**________________

Physician: ☐ Dr. Maulik Bhalani ☐ Dr. Arpit Patel ☐ Dr. Stephanie Epting ❑ Dr. Bryan Thomas ☐ Dr. Srinivasan Sathya ❑ Dr. Shawn Murphy ❑ Dr. Maria Cristancho

Your health is our priority. Please carefully read the instruction sheet in its entirety. Please arrive 20 minutes prior to your scheduled procedure.

PLEASE CONTINUE TO TAKE ALL REGULARLY SCHEDULED MEDICATIONS (INCLUDING HIGH BLOOD PRESSURE, DIABETES, THYROID) EXCEPT FOR BLOOD THINNING MEDICATIONS ON THE BLOOD THINNING MEDICATION LIST BELOW.

No solid food 6 hours prior to procedure. You may have **clear liquids** up to 2 hours prior, **but nothing by mouth after that.**

Please remember to take a shower on the morning of your scheduled procedure as this creates a more hygienic environment and may decrease your chance for skin related infections.

Please wear loose and dark clothing for your procedure such as sweat pants or loose t-shirts, and please keep in mind that your clothing may become stained from the cleaning solutions used by your physician. Please wear low heeled shoes and leave your jewelry and valuables at home.

If you are taking any anti-biotics, the procedure must be postponed until you have finished your anti-biotics.

See page 2 for blood thinner list of medications that need to be stopped prior to procedure.

You must notify the physician prescribing the blood thinner before stopping them AND we must have documentation from the prescribing physician allowing you to stop the blood thinner as instructed above.

You may continue Flector Patch, Lidoderm Patch, Celebrex, Tylenol/Acetaminophen or other medications including "opiate" pain medications without interruption.

If you have a temperature (100 F or above) or have a cold or the flu, or have other significant changes to your health, **please call us before you come in for your procedure**.

Bring your insurance card and your driver's license with you to your procedure.

YOU MUST HAVE A DESIGNATED DRIVER. Your driver **must be known to you;** a friend or family member. Do not take a cab or Uber without a responsible adult.

YOU MUST HAVE A CAREGIVER remain with you for 8 hours following your procedure.

It is the policy of Florida Pain Medicine that patients **DO NOT** operate motor vehicles or heavy machinery on the day of the procedure. Please arrange for a driver as you cannot be discharged to a taxi service or take public transportation such as a bus without a caregiver with you.

MEDICATION POLICY:

If appropriate, controlled medications (narcotics, muscle relaxants, and sedatives) may be prescribed prior to discharge from your procedure. Prescribing controlled medications over the phone is avoided. If additional medications are requested, an office visit for evaluation will be scheduled or you may need to go to the emergency room.

BLOOD THINNING MEDICATIONS LIST:

Abciximab (Reopro)	2 days
Aggrenox (Dipyridamole)	7 days
Aggrastat (Tirofiban)	7 days
Agrylin (Anagrelide Hydrocholoride)	7 days
Angiomax (Bivalirudin)	Ask prescribing physician
Arixtra (Fondaparinox)	24 hours prior/after procedure
Apixaban (Eliquis)	4 days
Aspirin	7 days (*hold for L1 and above)
Coumadin (Warfarin)	5 days, LABS day of procedure; INR < 1.2
Dabigatroban (Pradaxa)	5 days
Effient (Prasugrel)	Ask prescribing physician
Eptifibatide (Integrillin)	8 hours
Exanta (Eligatran/Ximeligatran)	Ask prescribing physician
Flolan (Epoprostenol Sodium)	24 hours prior/after procedure
Fondaparaneux (Arixtra)	5 days
Fragmin (Dalteparin)	7 days
Heparin	4 hours prior/after procedure
Integrilin (Eptiflbatide)	7 days
Iprivask (Desirudin)	Ask prescribing physician
Lovenox (Exnoxaprin)	12 hours
Normiflo (Ardeparin)	7 days
Novastan (Argantroban)	Ask prescribing physician
NSAIDS, Fish Oil Gingko, Garlic, Ginseng	5 days (*hold for L1 and above)
Orgaran (Danaparoid)	7 days
Pel-santine (Dipyridamole)	7 days
Plavix (Clopidogel)	7 days and MD approval
Pletal (Cilostazol)	7 days
Prasugrel (Effient)	10 days
Refludan (Repiludin)	7 days
Ticagrelor (Brilinta)	5 days
Ticlid (Ticlopidine)	14 days
Tirofiban (Aggrastat)	8 hours
Xarelto (Rivaroxaban)	3 days
All herbals (including Green Tea)	7 days
High Dose Vitamin E	7 days

**All patients MUST consult with and have the approval of their prescribing physician for appropriate directions BEFORE stopping the above medications. For this process, our office will need a note/script from the prescribing physician stating that you have been cleared to stop the above medicine and the amount of days needed to stop the medicine prior to your procedure. This note will be good for one year from when written and will be scanned into your file at our office. If you take any of these medications, you will need to call your prescribing physician to get their permission to hold these medications before we can schedule your procedure.

***The above are not the only medications or herbals/ingestible items that can thin the blood, please verify with your physician prior to taking any other medications or substances.
****You may take Tylenol or Acetaminophen and any pain medications as prescribed by your doctor.

❑ A staff member from Florida Pain Medicine reviewed my pre-operative instructions either in writing or verbally over the phone. I understand and wish to proceed with my procedure. **Pt. Initials:______**

❑ **You can review your procedural consent and post-op instructions online at www.FloridaPainMedicine.com. Click on PATIENTS, then click on Consent or Post-op Instructions.**

Patient Signature:____Date:___________Time:__________

Form date: 11/27/19

FLORIDA PAIN MEDICINE

(813) 388-2948

INTERVENTIONAL PAIN PROCEDURE POST PROCEDURE INSTRUCTIONS

❑ LOCAL ❑ ORAL SEDATION ❑ IV SEDATION

Patient Name:____**DOS:**_______________

Physician: ☐ Dr. Maulik Bhalani ☐ Dr. Arpit Patel ☐ Dr. Stephanie Epting ❑ Dr. Bryan Thomas
☐ Dr. Srinivasan Sathya ❑ Dr. Shawn Murphy ❑ Dr. Maria Cristancho

You must have a caregiver remain with you for 8 hours.

ACTIVITY:

You may resume all your normal activities as tolerated after your procedure. Do not drive or operate heavy equipment for the remainder of the day. Please be advised that any life altering decisions should not be made on the day of your procedure. No smoking for 24 hours. No alcoholic beverages for 24 hours following your procedure. Always have assistance when walking up or down stairs as you may have numbness or weakness in the extremity related to the procedure which could cause it to give out.

DIET:

Advance from clear liquids to regular diet as tolerated after your procedure.

ICE:

Follow your surgeon's recommendations.

Dr. Bhalani: Ice for 30 minutes every 2 hours or as tolerated for the first 24 hours.
Dr. Patel: Ice for 10 minutes, then remove ice for 30 minutes, then repeat as tolerated for the first 24 hours.
Dr. Epting: Ice for 10 minutes, then remove ice for 30 minutes, then repeat as tolerated for the first 24 hours.
Dr. Thomas: Ice for 15 minutes, then remove ice for 15 minutes, then repeat as tolerated for first 24 hours.
Dr. Sathya: Ice for 15 minutes, then remove ice for 15 minutes, then repeat as tolerated for the first 24 hours.
Dr. Murphy: Ice for 30 minutes every 2 hours or as tolerated for the first 24 hours.
Dr. Cristancho: Ice for 30 minutes every 2 hours or as tolerated for the first 24 hours.

WOUND:

Band-aids may be removed after 24 hours and do not need to be replaced. Larger dressings should be kept clean and dry, and also changed as instructed by your physician.

BATHING:

Showers may be taken the day after your procedure unless otherwise instructed, changing the dressing when completed.

MEDICATIONS:

Continue your usual medications after the procedure remembering the above restrictions if another injection is planned. If blood thinning medications were stopped, please resume them 12-24 hours after your procedure.

NOTIFY FLORIDA PAIN MEDICINE IMMEDIATELY FOR:

INFECTION:

Signs include: Fever, excessive redness or discharge at the wound site.

NEUROLOGIC SIGNS/SYMPTOMS:

- Numbness lasting over 12 hours that is different from your pre-procedure condition.
- The inability to move an arm or leg.
- New weakness that is over 24 hours old.
- Severe back pain.
- Chills or fever of 100.4 degrees F or greater.

DIFFICULTY BREATHING:

Continuous shortness of breath, cough and/or painful breathing.

ADVERSE MEDICATION REACTION:

For rash, welts, or excessive itching, notify the physician on call. Steroids given in the injections can occasionally cause temporary side effects that may include a light rash, redness or flushing in the face or possible weight gain.

These should resolve themselves within one to two weeks. It can also cause impaired glucose levels in diabetic patients which need to be monitored. If you have a history of peptic ulcers or acid reflux, notify your physician as steroids could possibly worsen the condition for one to two weeks.

URINARY RETENTION:

If unable to urinate for 6-8 hours following the procedure, please notify the office.

NAUSEA OR VOMITING:

If persistent and unable to tolerate clear liquids for over 6-8 hours, notify the office.

PAIN:

Soreness at the injection site is expected. This may also lead to localized muscle spasm and pain referred to other areas away from the injection site. Sometimes the original pain may return or occasionally get worse after a treatment. Notify the office only if your pain medications, anti-inflammatories, ice and/or heat are ineffective.

For a true medical emergency, please call 911 or go to the nearest emergency room.

Patient / Caregiver's Signature:____

Print Name:____

Date:____________________ Time:__________________

FLORIDA PAIN MEDICINE

PRE OPERATIVE PREGNANCY TESTING

Patient Name:_______________________________________Date:_____________

As a routine part of the pre-operative physical exam and testing, all women of childbearing age are asked about their pregnancy status and last menstrual period. Women who deny pregnancy will be asked to sign a pregnancy waiver (see below). If unsure, a urine pregnancy test will be offered to you. As there are risks to anesthesia and procedure, the benefits of this simple test to potential mother and baby are enormous. Your physician will discuss these issues with you and answer any questions you may have. All patients, however, for reasons of privacy or otherwise, may refuse to have this urine pregnancy test performed. We ask only that you fully understand the potential risks of surgical intervention and anesthetic agents on the developing baby, as well as the material implications of the procedure and anesthesia. We also ask that you be truthful in answering questions that your doctor and nurse will ask of you regarding time of last period, sexual activity, etc. Our goal is to provide the safest, highest quality of medical care. If you have any questions, please consult your physician.

PREGNANCY WAIVER FORM

☐ I, ______________________________, certify that the risks of the procedure and anesthesia while pregnant have been explained to me, and I am not pregnant.

☐ If the chance of pregnancy is in question, I have been offered the opportunity to take a pregnancy test and I decline. I hereby release the office of any liability if I am indeed pregnant at the time of the procedure and provision of anesthesia.

____
Patient Signature / Guardian / Parent

____
Witness

☐ N/A - ☐ Hysterectomy ☐ Refused pregnancy test for personal reasons

PREGNANCY TEST RESULTS

UHCG Results: Positive (+) Negative (-)

Lot #:_____________________________ Expiration Date:____________________

Testing Personnel:____

Date:___________________________________ Time:_______________________

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Discharge Instructions

Spinal Cord Stimulators, Intrathecal Pumps, Vertebral Augmentation, Lumbar Decompression & Discograms

Patient Name:____DOS:_______________

1. **Immediate Postoperative Period**: It is normal to feel dizzy and sleepy for several hours after procedure. Therefore, you should not drive, operate any equipment, sign any important papers, or make any significant decisions until the next day.

2. **Diet:** Start with clear liquids. Progress to solids over the next 6 hours. You will likely have received pain medication that may cause nausea and indigestion. Soups and foods that are easy to digest are best tolerated as you begin to eat (avoid spicy and fatty food). Drink plenty of fluids. Do not drink alcoholic beverages for at least 24 hours.

3. **Activities:** Keep activities to a minimum.
   - a: Period of at-home resting is recommended for 72 hours following the procedure.
   - b: **No twisting, turning, or bending should be attempted during this time.**
   - c: Call your physician if your pain is not controlled with pain medication.
   - d. Numbness lasting over 12 hours that is different from your pre-procedure condition.
   - e. The inability to move an arm or leg.
   - f. New weakness that is over 24 hours old.
   - g. Severe back pain.

4. **Temperature:** Please report any temperature over 100.4° degrees to your physician. Report any redness, swelling, excessive discharge, or foul odor from your surgical site. If you develop severe headache or marked neck stiffness and rigidity, please call your physician immediately and report to a local Emergency Department immediately.

5. **Care of the Wound/Special Instructions:**

Keep the surgical area and/or bandage clean and dry.
Follow your surgeon's recommendations:
Dr. Bhalani: Ice for 30 minutes every 2 hours or as tolerated for the first 24 hours.
Dr. Patel: Ice for 10 minutes, then remove ice for 30 minutes, then repeat as tolerated for the first 24 hours.
Dr. Thomas: Ice for 15 minutes, then remove ice for 15 minutes, then repeat as tolerated for first 24 hours.
Dr. Sathya: Ice for 15 minutes, then remove ice for 15 minutes, then repeat as tolerated for the first 24 hours.
Dr. Epting: Ice for 10 minutes, then remove ice for 30 minutes, then repeat as tolerated for the first 24 hours.
Dr. Murphy: Ice for 30 minutes every 2 hours or as tolerated for the first 24 hours.
Dr. Cristancho: Ice for 30 minutes every 2 hours or as tolerated for the first 24 hours.

Showering should not be attempted postoperatively until your physician instructs you to do so. Sponge bed bathing is acceptable. Keep the dressing or wound area dry at all times.

Please keep your dressing intact. Change dressing only if/or instructed by your physician. If you are prescribed a neck collar or abdominal binder, wear them as instructed by your physician.

For patients with functioning stimulators, spinal cord stimulation may be variable and may change with position. Do not be alarmed. Your unit has a high degree of reliability and usually only minor adjustments are needed. If adjustment is not satisfactory with your hand-held programmer, please contact our office at **(813) 388-2948** or your spinal cord stimulator representative.

You may require modification in your pain medication for immediate postoperative discomfort. Please discuss this with your physician and make changes only as your physician advises.

6. **Possible Problems:** Report any neurological changes, such as new numbness or weakness or new severe back pain. New changes are never normal and may require emergency treatment. If you have any questions or are concerned that something isn't right, please feel free to call our office. If you feel that you're having a true emergency, you must report immediately to an emergency room in the emergency room physician will contact the on-call physician directly.

For phone calls after hours please call (813) 388-2948; ask for a pain physician on call. Otherwise call the clinic between 7.30 AM and 4.30 PM, Monday through Friday, telephone (813) 388-2948. Please keep a diary noting your pain responses and side effects every few days until follow-up visit. Write it down so you don't forget. Bring the diary with you to next meeting with your physician.

These instructions have been explained to me. I understand them and received a copy.

If you have a true medical emergency, call 911 or go to the nearest emergency room.

You must have a caregiver remain with you for _________ hours.

Patient/caretaker's Signature: ____

Date: ______________________ Time: _____________________

Interpreter (if applicable): ____

Staff: ____

FLORIDA PAIN MEDICINE

Information on Non-opioid Alternatives for the Treatment of Pain
Acknowledgment Page

I have received the Pamphlet issued by the Florida Department of Health, and my physician has reviewed with me the advantages and disadvantages of the use of nonopioid alternatives for the treatment of pain.

Patient Name:____

Patient's Signature:____

Date:________________________________Time:________________________

Witness:____

Physician Name:____

Form date: 6/30/19

FLORIDA PAIN MEDICINE

Acknowledgment of Preoperative and Postoperative Instructions

Patient Name (print):____

I have received a written copy of my preoperative and postoperative instructions for my planned, upcoming procedure with Florida Pain Medicine. I have had the opportunity to review the instructions and ask any questions I had.

_______________________________ _____________ __________
Patient Signature Date Time

____
Witness

Form date: 4/4/18

FLORIDA PAIN MEDICINE

PRE-OP / POST-OP STANDING ORDERS

LOCAL / LOCAL-ORAL SEDATION

Patient Name:____Date:_______________

Allergies/Reaction:____

____

PRE-OP (MA-Local/Oral Sedation only)

- ☐ 1. Consent signed
- ☐ 2. Urine HCG on female patients of childbearing age or waiver signed.
- ☐ 3. Glucose testing for diabetic patients.
- ☐ 4. PT-INR

Signature:____________________

POST-OP (MA-Local/Oral Sedation only)

- ☐ 1. HR, BP, Resp function and SaO_2 will be monitored post procedure in the procedure room as long as vital signs are stable and return to baseline.
- ☐ 2. Patient is cleared to be discharged and the physician has signed and documented time on discharge order; patient may leave with responsible adult.

________________________________ ________________________________

Physician's Signature MA Signature

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FLORIDA PAIN MEDICINE
SURGICAL / PROCEDURE TIME-OUT CHECKLIST

Patient Name:____DOB:__________Date:________

FINAL VERIFICATION TIME-OUT	CHECK	INITIALS	TIME
A. Confirmation: Prior to the administration of anesthesia, the Physician(s) or physician assistant(s) performing the procedure and another Florida licensed health care practitioner shall verbally and simultaneously confirm the patient's identification, the intended procedure and the correct surgical/procedure site prior to making any incision or initiating the procedure. The patient's identity was confirmed using the patient's name and date of birth. Team members present who confirmed the above. ☐ M. Bhalani, MD ☐ A. Patel, DO ☐ S. Epting, DO ☐ B. Thomas, MD ☐ S. Sathya, MD ☐ S. Murphy, DO ☐ M. Cristancho, MD ☐ Christina Helm, RN, Anesthesia Provider ☐ Rebecca LaBrie, RN, Anesthesia Provider ☐ Jeannene Silva, RN, Anesthesia Provider ☐ Chris Hawley, MA ☐ Kendra Ramsey, MA ☐ Danielle Henderson, MA ☐ ________________________, MA ☐ ________________________, Anesthesia Provider ☐ ________________________, Resident Physician, Univers. of S. FL ☐ ________________________, Representative of Medical Device Co.			
B. The pause is completed at any time (but before the procedure is performed). If the physician(s) leave the room where the procedure is being performed, upon his or her return, the time-out must be performed again.	☐ N/A ☐ Performed again @ this time		
C. Anesthesia time out: The patient's identity was confirmed using the patient's name and date of birth.			
D. Allergies reviewed:			
E. Antibiotic given:			
F. Verified consult notes / orders for correct planned procedure.			
G. Physician saw patient immediately prior to confirmation of actual planned procedure.			

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FLORIDA PAIN MEDICINE
LOCAL / ORAL SEDATION PROCEDURE NURSE NOTE

Patient:____Acct#____________________Date:______________
Procedure:____with Dr. ❑Bhalani ❑Patel ❑Epting ❑Sathya ❑Thomas ❑Murphy ❑Cristancho
Consent Signed: ❑ Yes ❑ No UhCG: ❑ Positive ❑ Negative
Allergies/Reactions:____
____

Immediate Preop Evaluation by Surgeon:

Date:_____________ Time:______________ ASA Class: 1 2 3
Lung: ❑ CTA ❑ Other:________________________ Heart: ❑ RRR ❑ Other:________________________
Cleared by Surgeon for (OBS) Procedure? ❑Yes ❑No
Surgeon's Comments:____
Surgeon's Signature:____

PO Prior to Procedure:

❑ Patient brought prescription from pharmacy. Rx verified by staff before administration.

Med	Dosage	Time Taken	Reason	Initial
Valium	5 mg		Pre-medicate	
Valium	5 mg		Pre-medicate	

NPO: ❑ Liquid:__________________ ❑ Solid: ____________________
Procedure Position: ❑ Prone ❑ Supine ❑ Side lying
BS:_________________@ _____________ ❑N/A
In Room:____________ Procedure Start:___________ Procedure Stop:___________ Fluoro Time:__________
Prep: ❑ Hibiclens ❑ Alcohol ❑ Betadine ❑ Other:________________________ Dressing:_____________

Vital Signs:

Area	Time	B/P	HR	SaO2	LOC
Pre-op					
Procedure Room					
Post-Procedure					

LOC: 2- Awake and aware 1- Arousable 0-Not responding

Medications Administered by Physician:

Medication	Dosage	Lot #	NDC #	Exp. Date
Lidocaine 1%				
Isovue 300ml				
Sodium Bicarbonate 8.9%				
Sodium Chloride **0.9%**				
Bupivacaine 0.5%				

Compounded Medication: ❑ N/A
Medication:__________________________ Lot #:_________________ Exp. Date:_______ Dosage: ________________________
Pharmacy:__________________ Site of Injection:________________ Amount Administered:__________ Date Administered:_______

Discharge instructions reviewed and copy given: ❑ Yes ❑ No

Discharge vitals: Time:____________ B/P:____________ HR:__________ SaO2:__________ LOC:__________

Notes/Time:____
____

MA's Signature:____

Discharged by: (physician)____Time:______________
Dr.: ❑Bhalani ❑Patel ❑Epting ❑Thomas ❑Sathya ❑Murphy ❑Cristancho

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FLORIDA PAIN MEDICINE
POST-PROCEDURE TELEPHONE CALL REPORT

Patient: __________________________ D.O.B.:_______ Procedure Date:_________

Procedure: ____
____

Physician: ❑Dr. Bhalani ❑Dr. Patel ❑Dr. Epting ❑Dr. Thomas ❑Dr. Sathya
❑Dr. Murphy ❑Dr. Cristancho

Patient Telephone Number:____

Follow-Up:

If call is answered:

Call by: ____
Spoke to: ____
Time/Date of Call: ____
Post-op Appt. Date: ___________

If call is not answered:

❑ 1st Attempt - Left message: Time:____________ Date:________ Initials:______
❑ 2nd Attempt - Left message: Time:____________ Date:________ Initials:______
❑ Letter sent to patient Date:________ Initials:______

Check List:

Yes	No	
❑	❑	Bleeding?____
❑	❑	Pain? If yes, is pain relieved by medication?_______________________
❑	❑	Excessive swelling?______________________________________
❑	❑	Fever?____
❑	❑	Vomiting?____
❑	❑	Other?____

If patient returned call: Spoke to:____
Time:__________________ Date:_________________

Comments or Complications:

____
____
____
____
____

Dr. Notified: Date:_________________ Time:_______________

Staff Signature: ____

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FLORIDA PAIN MEDICINE
LEVEL 1 LOG

Surgery Date	Patient #	Physician	Preoperative Diagnosis	Procedure	Surgery Duration	EBL	Post-op Condition	Adverse Events

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CHART AUDIT - FLORIDA PAIN MEDICINE

Chart Audit By: ______________________________________ Date: __________________________
Patient's Initials / Pt ID #: _________________ DOS:_______________________ Male / Female
Surgeon: ____Pt Wt: __________ Age: ____
Procedure: ____

Sx time:	Anesthesia time:

☐ Anesthesia Consent: signed /timed choice of anesthesia provider ☐ Anesthesia provider: RN	☐ Consult for Sx:___________________ ☐ H&P: __________________________ ☐ Anesthesia Record - Vitals Q 5 min, Documentation of drugs & dosages, O2sat, EKG ☐ Medication totals

☐ Consent procedure(s) Signed, Dated & Witnessed, Timed	☐ Immediate Pre op Eval - Surgeon
☐ ASA 1 2 3	☐ Cleared for OBS
☐ Level of Surgery 2	☐ Surgical Log MD / DO
☐ 64B8/64B15 Verbiage on the consent	☐ Time out ☐ Anesthesia Time Out
☐ PACU Record with signed / timed D/C order by Surgeon (CRNA)	☐ Intra op record (RN sedation & PACU) ☐ Flouro time
☐ Clearance: Surgeon / outside Physician Dated: ______________________ (Clearance, EKG, Labs)	☐ Pre-op instructions ☐ Post-op instructions ☐ Acknowledgment signed (for both) ☐ Hospital cross coverage form ☐ Non-opioid form ☐ E-Forcse checked
☐ Post op telephone call	☐ Op Note (Signed, EBL, Complications)
☐ Standing Orders (pre, intra & post)	☐ Labs initialed / dated ☐ HCG performed (+) (-) / Waiver ☐ Allergies / Reactions noted Rev 9/10/19

The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

Notes:

____
____
____
____
____