**Outpatient Consent for Procedure**

I, hereby authorize **Provider Name, M.D.**, his associates and assistants, to perform the following procedure:

❒ Epidural Steroid Injection (ESI) ❒ SI Joint Injection (SI) ❒ Facet Joint Injection (FACET)

❒ Transforaminal Steroid Injection (TFESI) ❒ Trigger Point Injection (TPI) ❒ Discography (DISCO)

❒ Greater Occipital Nerve Block (GONB) ❒ Medial Branch Block (MBB) ❒ Radiofrequency (RF)

❒ Selective Nerve Root Block (SNRB) ❒ Other:

on the following site:

❒ Right ❒ Left ❒ Bilateral ❒ Midline ❒ Level:

*Legend: ⧫ Cervical (C) ⧫ Thoracic (T) ⧫ Lumbar (L) ⧫ Sacral (S)*

The injection you will receive today will include a local anesthetic which may provide temporary pain relief but may also cause some weakness or numbness of your legs or of your arms.  This should wear off within several hours after the injection.

The potential benefits of the procedure, alternative treatments and consequences of no treatment have been explained to me. I understand that any procedure involves some serious and possibly fatal risks and side effects. The risks and side effects may include, but are not limited to: infection, bleeding, nerve injury, paralysis, blood clots, stroke, heart attack, allergic reactions, damage to nearby organs, need for re-operation and pneumonia. **I understand that this procedure may not be successful in alleviating my pain and/or may require more than one injection.** Some other significant additional risks of the procedure may include:

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* I have not taken any anticoagulant medication for \_\_\_\_ day(s) prior to this procedure.
* I have not taken any aspirin for \_\_\_\_\_ day(s) prior to this procedure.
* I understand that during the course of the procedure(s), unforeseen conditions may arise that require an extension of the original procedure(s) or different procedure(s) from the one described above. I therefore, authorize and request that the above-named physician, his/her assistant or designee, perform such procedure(s) as appears necessary and desirable in their exercise of professional judgement. This will extend to treating all conditions that require treatment but are not yet known at the time the procedure commenced.
* I have been informed by Athens Spine Center that I am not to drive after my procedure and that I have a driver for my post-procedure transportation.
* If a healthcare worker comes in direct contact with a patient’s blood or bodily fluids, I understand that the patient’s blood may be tested for the Hepatitis B virus, Hepatitis C virus, the HIV virus, or any other virus’ to determine whether or not the viruses are present, endangering the healthcare of the Athens Spine Center employee.

PLEASE SIGN BELOW:

**⮚**

*Date/Time Signature of Patient / Responsible Party*

I certify that the procedure(s) described above, including the risks, possible complications, anticipated results, alternative treatment options, including non-treatment, have been explained by me to the patient or his or her legal representative before the patient or his/her legal representative consented. The patient has consented.

**⮚**

*Date/Time Treating Physician/Witness*