

Procedure Consent Form

Patient Name:		Age:	Sex: M F
Address:		Birth Date:	
Surgeon:	Date of Surgery:	Home Phone:	
		Cell Phone:	

CONSENT TO OPERATION AND RENDERING OF MEDICAL SERVICES

<input type="checkbox"/> Cervical Epidural Steroid <input type="checkbox"/> Cervical Facet Block <input type="checkbox"/> Cervical Foraminal Epidural <input type="checkbox"/> Biaculoplasty <input type="checkbox"/> Discogram <input type="checkbox"/> Extradural Myelogram <input type="checkbox"/> Intercostal Nerve injection Medial Branch Blocks <input type="checkbox"/> Ilioinguinal/Genitofemoral Injection <input type="checkbox"/> Major Joint Injection: <hr style="width:50%; margin-left:0;"/>	<input type="checkbox"/> Lumbar Epidural Steroid <input type="checkbox"/> Lumbar Epidural Lysis <input type="checkbox"/> Lumbar Facet Block <input type="checkbox"/> Lumbar Foraminal Epidural <input type="checkbox"/> Lumbar Sympathetic Block <input type="checkbox"/> Lumbar Sympathectomy <input type="checkbox"/> Pump Refil <input type="checkbox"/> Medial Branch Rhizotomy <input type="checkbox"/> Vertebroplasty <input type="checkbox"/> Other: <hr style="width:50%; margin-left:0;"/>	<input type="checkbox"/> Occipital Nerve Block <input type="checkbox"/> Sacroiliac Injection/ Arthrogram <input type="checkbox"/> Selective Nerve Block/ Neurogram <input type="checkbox"/> Thoracic Epidural Steroid <input type="checkbox"/> Thoracic Facet Injection <input type="checkbox"/> Thoracic Sympathetic Block <input type="checkbox"/> Trigger Point Injection <input type="checkbox"/> Trial Spinal Cord Stimulator <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral
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I, the above mentioned patient hereby authorize the above-named surgeon and/ or associates or assistants of his choice to perform the operation indicated above and/or such operations and/ or any other therapeutic procedures upon me they may deem necessary or advisable. The necessity for the operation, the potential benefits, alternatives, and the potential risks of the operation have been explained to me and no warranty or guarantee has been made as to the result or cure. I have been advised of the comparative risks, benefits and alternatives associated with performing the procedure in an office or surgical center instead of a hospital.

I hereby authorize the above named surgeon and/ or his associates or assistants to provide such additional services for me as he or they may deem necessary or advisable including procedures different from those now contemplated, and including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology, and I hereby consent thereto.

The risks of the procedure including potential problems that might occur during recuperation include but are not limited to increased pain, bleeding, infection, headache, nerve/spinal cord injury, and/or loss of sensory or motor function, seizure death.

I authorize members of the anesthesia staff to prescribe and use any such anesthetics and/or adjunct agents, as they may consider advisable.

I/We Hereby authorize all doctors, pharmacists, hospitals, S.E. PA Pain Management or other institutions rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered, (including copies of my records). A photo-static copy of this authorization shall be considered as effective and valid as the original.

NOTICE: Any legal claim or civil action, including, but not limited to, a claim for medical malpractice in any way related to this admission/procedure, and the medical services provided by S.E. PA Pain Management or it's employees, shall be brought solely in the Courts of Montgomery County, in the Commonwealth of Pennsylvania.

If patient or undersigned does not agree to the above paragraph, then he/she will initial here. _____

The undersigned certifies that he/she has read the above and is the patient, parent, guardian or representative authorized to execute the above and accept its terms and risks.

PATIENT SIGNATURE _____

SURGEON'S SIGNATURE _____ DATE _____

If patient is a minor or unable to sign, complete the following: _____ Patient is a minor _____ Patient is unable to sign

because, _____

Parent/Guardian	Relationship	Surgeon Signature	Date
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**PLEASE DISCONTINUE THE FOLLOWING MEDICATIONS AND/OR VITAMIN SUPPLEMENTS
FOR THE STATED NUMBER OF DAYS PRIOR TO YOUR PAIN PROCEDURE**

Suspension Period (Days)	Generic Name	Brand Name(s)
14 Days (2 Weeks)	Ticlopidine	Ticlid
7 Days (1 Week)	Clopidogrel Bisulfate	Plavix
	Etanercept	Enbrel
	Mesalamine	Asacol, Rowasa
	Olsalazine Sodium	Dipentum
	Prasugrel	Effient
	Ticagrelor	Brillinta
5 Days	Abciximab	Reopro
	Aspirin (325 mg/day and above)	Bayer, Ecotrin, Durlaza
	Aspirin with Dipyridamole	Aggrenox
	Dabigatran	Pradaxa
	Warfarin	Coumadin
3 Days (72 Hours)	Apixaban	Eliquis
	Edoxaban	Savaysa
	Rivaroxaban	Xarelto
2 Days (48 Hours)	Cilostazol	Pletal
	Diclofenac	Arthrotec, Zipsor, Voltaren
	Fenoprofen	Fenortho, Nalfon
	Fondaparinux	Arixtra
	Etodolac	Lodine
	Ibuprofen	Advil, Motrin, Duexis
	Indomethacin	Indocin
	Ketorolac	Toradol, Acular
	Meloxicam	Mobic
	Nabumetone	Relafen
	Naproxen	Aleve, Naprosyn
1 Day (24 Hours)	Dalteparin	Fragmin
	Enoxaparin Sodium	Lovenox
	Eptifibatid	Integrilin
	Tirofiban	Aggrastat