NAME/DOB:________________________________

(Please print)

INTERVENTIONAL SPINE & PAIN
17051 N. Dallas Pkwy, Suite 300
Addison, TX 75001

INFORMED CONSENT FOR PROCEDURE

You have a pain condition that has not been relieved by routine treatments and it is now indicated to receive interventional treatment. There is **no guarantee** that a procedure will cure your pain, and in rare cases, it could become worse. The degree and duration of pain relief varies from person to person, so, at your follow up we will re-evaluate your progress, and then determine if further treatment is necessary.

Please inform your provider or clinical staff if you are taking any blood thinners, such as ***Coumadin, Plavix, Pradaxa, Eliquis, Brilenta, Lovenox, Heparin, NSAIDS or others***, as these can cause excessive bleeding and many procedures cannot be performed. If you are experiencing fever, cold or flu symptoms, or and infections, or are on antibiotic medications prior to your procedure, please make us aware.

Risks include infection, bleeding, bruising, and allergic reaction, and increased pain, nerve damage involving temporary or permanent pain/numbness or weakness, and even death.

You understand that are serious risks to a pregnancy survival with the exposure to these medications or X-ray involved. If you are or could be pregnant do not proceed with the procedure unless previously cleared by your ob/gyn.

The incidence of serious complications listed above requiring is very low. Your physician believes the benefits of the above procedure outweigh its risks.

I authorize ***Mark LeDoux, M.D.*** to perform the following procedure:

Left Cervical Epidural Steroid Inj at C4-5

I certify this form has been fully explained to me, I have read it or have had it read to me, and I understand its contents. I also understand the risks and benefits of the procedure and I consent to the listed procedure and/or other indicated procedures.

Signature of Patient:____
Date/Time

Signature of Witness: ____
Date/Time

Signature of Provider:____
Date/Time

NAME/DOB:________________________________

(Please print)

INFORMED CONSENT FOR ANESTHESIA

I understand that the anesthesia technique to be used is determined by many factors including my physical condition, the type of procedure, as well as my own preferences.

I understand that certain unexpected complications may result from the use of any anesthetic, including, but not limited to, infection, bleeding, injury to blood vessels, blood clots, drug reactions, aspiration pneumonia, respiratory problems, and loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

MONITORED ANESTHESIA CARE WITH IV SEDATION OR GENERAL ANESTHESIA:
An unconscious or semiconscious state in which you may or may not be aware of your surroundings and may hear and be aware of talking and sensations.

I acknowledge that I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia, postoperative pain control, risk of non-treatment, or other hazards as they relate to the proposed procedure.

I certify that this form has been fully explained to me, I have read this form or had it read to me, I understand its contents, and therefore voluntarily consent to the administration of anesthesia to me during the planned procedure. I also confirm that NPO status provided to the staff and providers today is accurate.

Your Anesthesia provider today is: ***Priti Mohindru, CRNA***

Signature of Patient:____

Date/Time

Signature of Witness: ____

Date/Time

Signature of Anesthesia Provider__________________________________

Date/Time