Patient Information, Authorization & Informed Consent for Outpatient Injection Procedure

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

Name: ____ Date of Birth: _______________

Physician: ***Dr. Amit Bhandarkar***

The planned procedure:

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Diagnosis: ____

I acknowledge and understand that the following procedure or treatment has been explained to me (sometimes referred to as the patient) in layman's terms and I understand that it is to be performed as an outpatient procedure. This information is given to me so that I can make an informed decision about having a spinal injection procedure to treat my spine condition. The procedure is an injection or treatment to the affected or injured area of the body. The purpose of the procedure is to decrease pain, repair the injury, and promote healing.

The material risks associated with this procedure or treatment include but are not limited to the following: soreness, allergic reaction, infection, numbness, tingling, paralysis or partial paralysis, loss of partial loss of function of any limb or organ, severe loss of blood, pneumothorax, disfiguring scar and/or depigmentation, cardiac arrest, brain damage, mental status changes, disorientation, sensory disturbance, insomnia, mood swings, euphoria, depression, facial warmth or flushing, fluid retention, hypertension, hypotension, hyperglycemia, headaches, gastritis, menstrual irregularities, nausea, rash, fever, dizziness, Dural puncture resulting in headaches, cerebral spinal fluid leak, fistula, abscess or hematoma formation, steroid induced bone damage (avascular necrosis), skin necrosis, unknown developmental/birth defects for pregnant females, seizure, paraplegia or quadriplegia; temporary worsening of pain; change in pain, nerve damage; and even death.

Available alternatives to this procedure or treatment include: physical therapy, medication management, conservative care, or surgery. The likelihood of success of the above procedure is good to fair. If I choose not to have the procedure, I have been informed that my prognosis (my future medical condition) is still fair.

I understand that the physician, medical personnel and other assistants will rely on statements by the patient, the patient's medical history, symptoms, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure or treatment which has been explained.

I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure or treatment.

I understand I may receive conscious sedation based on the nature of the procedure. I understand it is better to avoid sedation for diagnostic procedures. I further consent to the administration of such anesthesia as may be necessary or appropriate for such procedures.

I understand that during the course of the procedure or treatment described above it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed at the time this consent was given. It may also be necessary or appropriate to have diagnostic studies, tests, anesthesia, x-ray examinations and other procedures performed in the course of my treatment. I consent to and authorize the persons described herein to perform such additional procedures and treatments, as they deem necessary or appropriate.

Depending on the patient's diagnosis and the procedure or treatment to be performed, it may be necessary or appropriate for tissues and specimens to be removed from the patient's body. I consent to the removal, testing, retention for scientific or teaching purpose, and disposal of such tissues and specimens within the discretion of the physician, facility or other healthcare provider.

I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education. By signing this form, I acknowledge that I have read or had this form read and/or explained to me and that I fully understand its contents. Additionally, I have read the office injection procedure manual. I also have been given ample opportunity to ask questions and that the questions have been answered to my satisfaction. All blank areas or statements that I did not approve were stricken before I signed this form.

For women only: I represent to my physician that I am not pregnant nor am I breast feeding at this time, and understand that there are risks of sedation or of the procedure to an unborn child.

The basic procedures of the proposed injection, the advantages, disadvantages, risks, possible complications, and alternative treatments have been explained and discussed with me by **Dr. Amit Bhandarkar**. Although it is impossible for the doctor to inform me of every possible complication that may occur, the doctor has answered all my questions to my satisfaction. I also realize that I should not drive myself home after the injection procedure. In signing this consent form, I am stating that I have read this form (or it has been read to me), and I fully understand it and the possible risks, complications and benefits that can result from the procedure. I also acknowledge that the doctor has addressed all of my concerns regarding this procedure.

Patient's Printed Name: ____

Signature of Person Giving Consent Date and Time (and relationship to the patient if person giving consent is not the patient)

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If the person giving consent is not the patient, state the reason why the patient is unable to consent:

____

Witness' Printed Name/Signature/ Date and Time:

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*Witness' Signature Date Time *Consent valid for 30 days from date of signature.*