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:

_____

_____

Diagnosis: _____

I acknowledge and understand that the above 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 Knee injection procedure to treat my Knee pain.

The procedure is an injection or treatment to the affected knee. The purpose of the procedure is to decrease pain by nerve blocks. The nerves supplying the knee joint (genicular nerves) will be blocked to assess the amount of pain relief as a first step. If there is good relief for the duration of block the second stage involves focally burning those nerves with Radio frequency ablation - done using needles placed near my knee joint using Xray guidance.

In these procedures, the most common of these complications include post-procedure bleeding and post-operative infection, swelling or bruising and discomfort. Other complications include injury to adjacent tissues, nerve injury (i.e., numbness). I understand that any of these complications may require additional surgery or procedure to correct.

The nerve to be blocked is in proximity of a blood vessels and there is a chance to injury to the blood vessel requiring further treatment or even surgery.

RFA ablation of the nerves around the knee causes increase in the pain for some period after the ablation. There is also a chance of getting skin burns.

The other risks associated with this procedure and use of medications or treatment include but are not limited to the following: soreness, allergic reaction, paralysis or partial paralysis, loss of partial loss of function of any limb or organ, disfiguring scar and/or depigmentation, cardiac arrest, brain damage, mental status changes, insomnia, mood swings, euphoria, depression, facial warmth or flushing, fluid retention, hypertension, hypotension, hyperglycemia, headaches, gastritis, menstrual irregularities, nausea, rash, fever, dizziness, steroid induced bone damage (avascular necrosis), skin necrosis, unknown developmental/birth defects for pregnant females, seizure, paralysis; temporary worsening of pain;

change in pain, nerve damage; and even death(extremely rare).

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 also am informed and fully understand that if I am to receive local anesthesia and other pain management agents, I will not operate a motor vehicle or operate any dangerous machinery after such administration and I will be accompanied to and from the office by a responsible adult, as necessary for the procedure, unless the local anesthesia is unrelated to cognitive and motor functions.

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, is advantages, 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)

_____

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:

_____

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