

PHYSICIANS' SPINE CENTER

CONSENT FOR I.V. CONSCIOUS SEDATION

I, _____, understand by signing this form that I am giving written consent for Dr. _____ to perform the procedure described below. The associated risks, benefits and possible alternative have been described to me and I agree to proceed with the procedure.

You have chosen I.V. conscious sedation for your procedure. During this conscious sedation you will be less aware of your environment and of any discomfort.

Risks include, but are not limited to: nausea and vomiting, bruising or tenderness of the veins or vessels into which the medications are placed, depressed respirations, and the extremely remote possibility that complications may require transport to a hospital for treatment.

I understand that I must not have anything to eat or drink for 6 hours prior to conscious sedation.

Patient Signature _____ **Date:** _____

The Doctors and the entire staff of Physicians' Spine Center are committed to quality patient care. Informed consent is crucial to this commitment. If you have any questions about the procedure planned, or if you do not fully understand the risks, benefits and alternatives as they are explained to you, please ask the Doctor for clarification prior to signing this form.

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

PATIENT'S NAME: _____

DATE: _____

The following has been explained to me and I understand that:

- 1) The REASON THIS PROCEDURE IS BEING PERFORMED is: _____
- 2) The NATURE OF THE PROCEDURE is: insertion of a needle into the disc, injection of iodine contrast and possibly administration of steroid and local anesthetic drugs.
2a) *In addition, minimal or moderate sedation may be used for pain control/management during the procedure.*
- 3) The PURPOSE OF THE PROCEDURE is: to detect the cause of your pain.
- 4) MATERIAL RISKS OF THE PROCEDURE include: infection. In addition, there may be other possible risks such as pain, weakness and numbness of the arms and legs, headache and worsening of your presenting symptoms.
- 5) The administration of a non-ionic contrast material may be necessary to use to obtain additional diagnostic information. Usually, contrast material is quite safe. However, any injection carries some risk of harm. Occasionally, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly (1:1,000), a serious reaction occurs. Very rarely (1-2:100,000) death has occurred related to contrast administration.
- 6) The LIKELIHOOD OF SUCCESS OF THE ABOVE PROCEDURE is: GOOD
- 7) PRACTICAL ALTERNATIVES TO THIS PROCEDURE include: no treatment, oral medication, and/or bed rest.
- 8) I understand that the physician, medical personnel, and other assistants will rely on statements about and/or from myself, my medical history, and other information in determining whether to perform the procedure or the course of treatment for my condition and in recommending the procedure which has been explained.

Please check any of the following characteristics you may have and alert the staff:

- A history of adverse reaction to contrast material with the exception of heat/flushing sensation or a single nausea/vomiting episode.
 - A history of asthma or allergy.
 - Significant heart disorder including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
 - Any drug allergy.
 - Diabetic
 - Pregnancy.
 - Taking any blood thinners.
- 9) 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.
 - 10) I consent to diagnostic studies, tests, local and/or general anesthesia, x-ray examinations, and any other treatment or courses of treatment relating to the diagnosis or procedures described herein as may be deemed advisable.
 - 11) I consent to the taking of photographs or the use of video recording equipment during the procedure for the purpose of medical education.
 - 12) Additional materials used, if any, for this procedure include: _____
 - 13) I voluntarily allow Dr. _____ OR an associate and all medical personnel under the direct supervision and control of such physician along with all other personnel who my otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.
 - 14) I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such procedures as they deem necessary or appropriate.
 - 15) If I choose not to have the above procedure, my prognosis (future medical condition) is: UNKNOWN
 - 16) I consent to the release of all records pertaining to my treatment to other physicians or health professionals involved in my case.
 - 17) **By signing this form I acknowledge that I have read or have had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions, that my questions have been answered satisfactorily, and that I knowingly and voluntarily give my complete unfettered consent to the procedures described herein. All blanks or statements requiring completion were filled in, and all statements I do not approve of were stricken before I signed this form. I have received additional information including, but no limited to, the materials listed above related to the procedures described herein, and I authorize you to give me reasonable and proper care by today's standards.**

Signature of person giving consent: _____ Date: _____

Relationship to patient, if not patient: _____ Time: _____

Patient unable to sign because: _____ Witness: _____

DISCOGRAM: PATIENT INSTRUCTIONS

After your discogram, you may experience pain in the areas of needle placement for some days. The pain should diminish over the course of three days after the procedure. The discogram may cause your usual pain to be more severe immediately following the test and for 12-24 hours thereafter.

If your pain persists for more than seven days or if you have new pain or severe worsening of your pain after seven days, you should call our clinic at: **404-257-1858**.

You may have received sedation or analgesic medicine during this procedure. **Do not drive or operate equipment until the next day after the procedure.**

PATIENT
SIGNATURE: _____ **DATE:** _____

DO NOT WRITE BELOW THIS LINE

Discharged by: _____ **TIME:** _____
Signature of radiologist

FILMS MAILED _____

FILMS GIVEN TO PATIENT _____

DISCOGRAM – PATIENT INFORMATION SHEET

This procedure is used to evaluate patients with neck pain with or without shoulder and arm pain or patients with back pain with or without hip and leg pain. The radiologist will use a fluoroscope to guide needle placement. Local anesthetic is injected in the skin and a needle is passed through the skin into the disc to be studied. In order to place the needle in the disc, the needle must pass nerve roots and striking nerve roots may cause radiating pain. This will be of short duration. Placing needles in the disc may be somewhat painful, but generous local anesthetic is used in an effort to diminish pain during needle placement. Iodine contrast material is then injected in each disc under study. These injections may reproduce your present pain (the pain for which you are being evaluated). That is an important part of the test. X-ray films will be exposed to show the internal structure of the disc. If pain is caused by these injections, local anesthetic will be injected into the disc to diminish the pain.

The purpose of this procedure is to determine which, if any, disc is causing your pain.

The risks of this procedure include infection, worsening of your pain, headache, back pain or neck pain. Disc infection is not likely to occur, but when it occurs it requires hospitalization for intravenous antibiotic administration.

This procedure is likely to demonstrate the disc causing your pain, if the pain is arising from any of the discs we study. Other procedures have been performed and additional procedures will probably be performed to further allow your doctor to determine the origin of your pain and its proper treatment.

The radiologist and technologist will answer any questions you may have prior to beginning this procedure.

PLEASE SIGN HERE TO ACKNOWLEDGE READING:
