

PHYSICIANS' SPINE CENTER
INFORMED CONSENT FOR FACET JOINT INJECTION
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 facet joint of the spine and injection of steroid and local anesthetic drugs.
- 3) The PURPOSE OF THE PROCEDURE is: to reduce inflammation and reduce your pain.
- 4) MATERIAL RISKS OF THE PROCEDURE include: infection, allergic reaction, paralysis, cardiac arrest or death. In addition, there may be other possible risks such as pain at the site of injection, weakness and numbness of the arms and legs, and increased pain.
- 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 (1-5:100,000), 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 may 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 not 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: _____

FACET JOINT INJECTION PATIENT INFORMATION SHEET

These injections are undertaken in an effort to stop the pain arising from the small joints behind your spinal canal. Abnormalities of these joints of the back may cause pain in the back, hips and/or neck pain, shoulder pain or arm pain.

A fluoroscope is used by the radiologist so that he can direct small needles through your skin into these joints. Each needle puncture causes pain approximately equivalent to needle placement for drawing blood. After needles are placed in these facet joints, two types of medication can be injected. Local anesthetic is injected in an effort to immediately stop your pain and to determine whether the pain is arising from these facet joints. Anti-inflammatory steroid medicine is also injected in an effort to provide long term pain relief. The local anesthetic effect lasts approximately three hours. The steroid medication begins to work about two days following injection. In the interval between the time the local anesthetic effect wears off and the time the steroid effect begins, your pain will probably return. Do not be discouraged by this, if the local anesthetic helped your pain immediately, the steroid will probably help your pain over the longer period. Steroids may provide relief for weeks or months and some patients never require any further treatment.

The injections may be somewhat painful for a short period but no long term harmful effect is likely. In over ten years experience with this procedure, we have no recorded case of infection or paralysis or serious long term harmful effect. Allergy to the injected medications is a theoretical possibility but has not yet been experienced.

If your pain is arising from the joints we inject, it will probably be significantly relieved by these injections. Other injection procedures may be indicated. Alternatives to this procedure include physical therapy and oral medication and surgical procedures.

This procedure is likely to improve your pain symptoms and is very unlikely to cause harm. The radiologist and technologist will answer any questions you may have prior to beginning this procedure. Also if you are a Diabetic and monitoring your blood sugar please expect a rise in your blood glucose following your facet injection.

PLEASE SIGN HERE TO ACKNOWLEDGE READING:
