

PHYSICIANS' SPINE CENTER
INFORMED CONSENT FOR ROOT SLEEVE 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 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 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:** _____

ROOT SLEEVE INJECTION

PATIENT INFORMATION SHEET

Root sleeve injections are undertaken to determine which specific nerve is giving rise to arm pain or pain in the hip or leg. The root to be injected is chosen by clinical information gleaned from your doctor's examination and from the radiologist's examination of your x-ray tests. If the root we inject is causing your pain, the injection will result in relief of the pain and determines the result of the procedure.

The radiologist will use a fluoroscope to identify the proper placement of the needle. A thin needle will be placed through your skin. As it enters the nerve root sheath, the needle strikes the nerve root and causes radiating pain in the arm or leg. You will be asked whether this pain is similar in distribution to the pain under evaluation. Iodine contrast material is then injected through the needle to be sure the needle is in the correct position. Then local anesthetic is injected through the needle and steroid medication may be injected in an effort to provide longer lasting relief. Following the injection, you will be questioned as to whether your pain has improved. Improvement in the pain indicates that the nerve injection is responsible for the pain and may aid your physician in selection of proper level for subsequent treatment.

This procedure is very unlikely to cause any long term harmful effect. In several years experience with this procedure we have recorded no long term nerve root damage. Some complications could theoretically include infection and nerve root damage. Few patients do experience an increase in their presenting pain in the days following the procedure but this is an unlikely result.

Other tests have been used and will be used in addition to this procedure. Nerve root sheath injections are among the many procedures that we use to determine the cause of pain and may be used in an effort to treat the pain.

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

PLEASE SIGN HERE TO ACKNOWLEDGE READING:
