Patient Label

Greater New Orleans Surgery Center

PAIN MANAGEMENT CONSENT

INFORMATION ABOUT THIS DOCUMENT
READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, (4) reasonable therapeutic alternatives and material risks associated with such alternatives, and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read carefully. Ask about anything you do not understand, and we will be pleased to explain.

1) Patient name: ____

2) Treatment/procedure: **PAIN MANAGEMENT PROCEDURE**
   Description, nature of the treatment/procedure

- ☐ Epidural Steroid Injection – To inject contrast followed by steroid medication with or without local anesthetic medication into the space beside the spinal cord in an attempt to provide lower back and/or lower extremity pain relief
- ☐ Sacroiliac Joint Injection – To relieve pain by injecting local anesthetic and anti-inflammatory medication into the painful joint or around the nerves which supply the joint to relieve pain.
- ☐ Facet Joint Injection – To inject contrast and local anesthetic mixed with an anti-inflammatory medication into the painful joint or around the nerves which supply the joint to relieve pain.
- ☐ Discogram – To inject contrast into the disc in an attempt to identify source of pain and evaluate the appearance of the disc, which may or may not be followed by injection of anesthetic with or without anti-inflammatory medication.
- ☐ Peripheral Nerve Block – To inject contrast and infiltrate local anesthetic and an anti-inflammatory medication around the nerve to decrease pain.
- ☐ Other: ____
- ☐ Intravenous sedation if determined to be necessary by my doctor
- ☐ X-ray guidance during procedure

3) Patient Condition:
   Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in Item 2 indicated and recommended for your chronic pain syndrome.

4) Material risks of treatment procedures:
   a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below.
   ☑ Risks generally associated with any treatment/procedure with local anesthetics are: death, brain damage, disfiguring scars, paralysis, the loss of or loss of function of body organs, the loss of or loss or function of any arm or leg, infection, bleeding and pain.
   ☑ Risks determined by your doctor are:
   1. Allergic, abnormal or hypersensitivity reaction to drugs or equipment which may be fatal
   2. Aspiration (inhalation) into the bronchi (airway) or lungs of stomach acids and foreign objects
   3. Leakage of cerebrospinal fluid
   4. Infection/abscess of bone (osteomyelitis) or soft tissues
   5. Convulsion (seizures)
   6. Epidural blood clot or abscess (bleeding or infection in the space adjacent to the spinal cord which may damage the spinal cord) or bleeding around the site
   7. Broken needles or catheters which may lead to complications and necessitate additional treatment
   8. Production of an unintended high level of anesthesia which may necessitate need for artificial respirators and insertion of a breathing tube
   9. Pain or discomfort during or after the procedure

10. Injury to the lips, tongue and inside of the mouth, airway, injury or chipped teeth
11. No relief or incomplete relief of pain or worsening pain
12. Loss of bowel or bladder function or sexual function
13. Heart attack or other heart problems
14. Decreased blood pressure or increased blood pressure
15. Shock
16. Nerve damage ranging from loss of sensation to total paralysis
17. Lung collapse requiring chest tube placement
18. Death
19. Brain Damage
20. Severe Headaches

b) Additional risks (if any) particular to the patient because of a complicating medical condition are: ________________________
____

5) Reasonable therapeutic alternatives and risks associated therewith, risks of no treatment: Bed rest, oral analgesics, physical therapy and surgery. Efficacy of each treatment modality (including epidural steroids) is variable, and may even worsen the pain.

6) ACKNOWLEDGEMENT / AUTHORIZATION AND CONSENT

a) No Guarantees: All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks of this or alternative procedures or as to the prospects of success, are made in the best professional judgment of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other respects of the medical treatment or surgical procedure.
b) Additional information: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.
c) Particular Concerns: I have had an opportunity to disclose to and discuss with the physician proving such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.
d) Questions: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any other questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner.
e) Authorized Physician: The physician (or physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in Item 2 is: **Michael Zeringue MD**
f) Physician Certification: I hereby certify that I have provided and explained the information set forth herein, including any attachment, and answered all questions of the patient, or the patient's representative concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Physician Signature: ______________________________________ Date/Time: _____________________

CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in Item 2 of this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of nay general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in Item 2 of this consent form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

____ ____
Patient or Person authorized to consent Date/Time Witness Date/Time

If someone other than the patient signs consent, state the reason and relationship: ____