ALGONE DFW
INTERVENTIONAL PAIN

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Procedural Consent Form

Patient Name: _____ **DOB:** _____ **Provider:** _____

Procedure: _____

Allergies: _____

Please initial and sign the following documentation, only after reading all of the information presented. If you have ANY questions, ask you provider before signing this form.

Initial

_____ **1**. I hereby consent to the above listed procedure(s), and/or administration of anesthetic or intravenous sedation by my provider.
_____ **2**. The reasons for recommending this procedure, along with the risks and alternative treatments or tests have been explained to me by my provider. I understand that it is possible I may receive minimal or no pain relief from this procedure.
_____ **3.** I understand that possible complications and risks include, but are not limited to:

• **Pain**	• **Nerve Pain**	• **Paralysis**
• **Infection**	• **Nerve Damage**	• **Increased Blood Sugar**
• **Short term or long-term increase of pain**	• **Seizures**	• **Death**
• **Hemorrhage**	• **Headaches**	• **Medication insertion outside intrathecal pain pump**
	• **Skin Discoloration**	

_____ **4**. I authorize the administration of any additional medications and/or further procedural action that is medically indicated and appropriate by my provider, in the case of any unforeseen complications that are unknown to my provider at the time my treatment is commenced.
_____ **5**. I am currently not on antibiotics and do not knowingly have an active infection.
_____ **6**. I do not have an allergy to Iodine, contrast dye, shellfish, local anesthetic, latex or corticosteroids.
_____ **7**. I am not on any blood thinners (anti-coagulants including but not limited to; Plavix, Coumadin, Xarelto, etc.)
_____ **8.** I am not on any NSAID (Non-Steroid Anti Inflammatory) medications or I understand if I am currently, I need to discontinue three days prior to my procedure date.
_____ **9.** I have a driver available if necessary and indicated by my provider.
_____**10**. I certify that this form has been explained to me, that I have read it, or have had it read to me, and that my questions have been answered to my satisfaction. I agree to proceed, as indicated by my signature below.
_____ **11.** I understand that there may be a charge associated with this procedure. The amount of that charge may be unknown until my insurance pays their portion of the billed amount. I agree to pay the balance that is determined patient responsibility.

_____	_____	_____
Patient Printed Name	**Patient Signature (or patient representative)**	**Date**
_____	_____	_____
Provider Signature	**Witness Signature**	**Date**

***For Females only:**
I certify that I am not knowingly pregnant: _____
LMP:_____ **Urine HCG results:**_____ **Type of Birth Control Used:**_____