Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

Pragya B. Gupta M.D., F.R.C.S. (Edin), D.A.B.P.M.

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CONSENT FORM

Forms

Full Name: _____ DOB: _____ Date: _____

TO THE PATIENT: 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. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Dr. Pragya B. Gupta has discussed with you, your condition and the recommended surgical, interventional, medical, or diagnostic procedure(s) to be preformed. This discussion was intended to ensure that you had the opportunity to receive the information necessary to make a reasoned and informed decision whether or not to consent to the procedure(s). This document is a written confirmation of that discussion and contains some of the more significant medical information discussed.

1. Based on this discussion, I understand that the following condition(s) may exist in my case

   _____

2. I understand that the procedure(s) proposed for treating or diagnosing my condition(s) is/are:
   Explain in lay terms:

   _____

3. I understand the necessity for the administration of sedation, or anesthesia when deemed appropriate.
4. I have been informed of the following:
   - Reasonably expected benefits of the proposed procedure, and the available alternatives, some of which include: No treatment, or to continue medical management with the use of medications.
   - Probability of success or failure and major problems of recuperation of proposed procedures.
   - Epidural administration of steroids such as Kenalog (triamcinolone), Celestone (Betamethasone), and Dexamethasone etc, Hyaluronidase which is not steroid but an enzyme preparation that helps in breaking scar tissue, is off-label use, but supported by medical literatures and is known to be safe.
   - Reasonably anticipated consequences if the procedure is not performed.

   _____

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5. I understand that all medical and surgical procedures involve risks to some degree. These risks may include the potential for infection (5% incidence of skin infection or wound infection), allergic reactions, bleeding, blood clots, brain damage, and even loss of bodily function or life. I have also been informed that the following additional risks and hazards may occur in connection with this Procedure: Epidural abscess (0.2 to 1.2 per 10, 000), paralysis, permanent nerve damage (1 in 15,000), spinal cord damage, headache (1 in 100), immunosuppression, increased pain, no pain relief, bowel or bladder dysfunction, sexual dysfunction, cerebrospinal fluid leakage. In case of use of catheter or spinal cord stimulator electrodes, there is a minor possibility of its shearing and being left behind in your body.

_____

6. I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of proposed procedure(s), unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be preformed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedures. I hereby voluntarily give my authorization and consent to Dr. Pragya B. Gupta, and his delegated associates to perform and/or assist in the proposed procedure described above.
7. I hereby authorize and consent to the taking of photographs or films during the procedure and their use for teaching and research purposes.
8. I hereby authorized and consent to the disposal of tissue necessarily removed as part of a procedure(s) for diagnostic and research purposes.
9. I have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of non treatment, the procedures to be used and risks and hazards involved, and I believe that I have sufficient information to give this informed consent.
10. I have been informed about the use of X ray machine for precise needle placement during the pain interventional procedures. I have been made aware of the side effects of X ray although they are extremely rare.
11. I also understand that in order to visualize the structures precisely as well as to prevent intra-vascular injection of medication, injection of contrast (dye) material will be undertaken as part of diagnostic study. I understand that the dye study is an integral part f all interventional procedures. I understand that the risks include but not limited to hives, vomiting, blood pressure drop, and breathing difficulty or severe drug related reaction resulting in organ damage or death.
12. Only for female patients: I am not pregnant.

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I certify that I have read and fully understand the contents of this form, that the disclosure referred to above were make to me, and that all blanks and statements requiring insertion or completion were filled in before I signed my name below. I hereby release my physician and any other participating health care providers from any and all liability for any unintended & or adverse effects that my result from these procedures.

_____ _____

Signature of Patient/Guardian Date Signature of Physician Date

_____ _____

Signature of Witness Date Signature of Spouse/Family Member Date

TO BE COMPLETED BY RECOVERY STAFF AT THE CENTER: 1. DIABETES YES / NO (NIDDM OR IDDM) 2. SICKLE CELL ANEMIA OR TRAIT. YES / NO 3. RENAL FAILURE YES/ NO. 4. MULTIPLE MYELOMA. YES/ NO 5. BRONCHIAL ASTHMA OR COPD YES / NO 6. HEMOLYTIC ANEMIA: YES/ NO 7. HYPOTHYROIDISM: YES/ NO 8. RECENT H/O OF MI OR CVA YES/ NO DATE: _____ **9. H/O REMOVAL OF SPLEEN YES / NO** 10. H/O OR ORGAN TRANSPLANT YES / NO _____ 11. RECENT HISTORY OF INFECTION YES/ NO. _____ 12. RECENT VACCINATION: YES / NO DATE:	13. BLOOD THINNER YES/ NO_____ (COUMADIN/ ASA/ PLAVIX/_____) 14. IF YES, WHEN STOPPED _____ 15. INR & PT, PTT DONE : YES/ NO 16. NPO SINCE WHAT TIME? _____ 17. HAVE YOU TAKEN YOUR HEART AND BP MEDICATION? YES / NO.