Patient Name:
DOB:

Consultants in Pain Medicine
5364 Fredericksburg Rd. STE 100, San Antonio, TX 78229

DISCLOSURE AND CONSENT FORM

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be 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 that you may give or withhold your consent to the procedure.

1. I voluntarily request that **Raul G. Martinez, M.D.,** as my physician, and such associates, technical assistants, and other health care providers as they deem necessary, to treat my condition which has been explained to me as:

   DIAGNOSIS:

   ___ Low back pain ___ Neck Pain ___Thoracic Pain
   ___ Other _____

2. I understand that the following surgical, medical and or diagnostic procedure (s) planned for me and I voluntarily consent and authorize the following:

   ___ Cervical Epidural Steroid Injection ___ Thoracic Epidural Steroid Injection
   ___ Lumbar Epidural Steroid injection ___ Transforaminal Lumbar Epidural Steroid Injection
   ___ Lumbar Facet Joint Injection ___ Cervical Facet Joint Injection
   ___ Sacral Iliac Joint Injection ___ Hip Joint Injection ___ Trochanter Bursa Injection
   ___ Radiofrequency thermoablation _____
   ___ Spinal Cord Stimulator Trial _____ Lumbar Discogram____
   ___ Cervical Facet Joint Injection ___ Thoracic Facet Joint Injection
   ___ Selective Nerve Root Block ___ Coccygeal Nerve block ___Trigger Point Injections
   ___Stellate Ganglion Block ___ Fluoroscopy (X-Ray)____Sympathetic Block,Lumbar
   ___Monitored Anesthesia Care (Sedation) ___ Other_____

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I understand that my physician may discover other or different conditions that may require additional or different procedures than those planned. I authorize my physician to perform such other procedures that are advisable in their professional judgment.

I understand that no warranty or guarantee has been made as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I realize that common risks related to surgical, medical, and/or diagnostic procedures are potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. Risks and hazards that may occur with monitored anesthesia care are potential for permanent organ damage, memory dysfunction/memory loss, drug reaction, respiratory problems or even death.

I realize that the following risks and hazards may occur in the connection with this particular procedure:

- Risks of injection include: pain, bleeding, infection, failure to decrease pain, permanent injury and neurological deficit.

- Spine injections carry the additional risk of: spinal hematoma and infection with cord and nerve damage which may be permanent, direct cord trauma or nerve trauma with permanent injury, and increased pain. Headache after spinal injection requiring additional treatment and/ or procedures may occur. More rare complications to include blood clots within the spine and brain as well as meningitis are also present with the potential for permanent neurological injury. Some of these conditions are life threatening.

Patient confirms that they have not consumed any blood thinners and herbals which may cause increased bleeding.

- The patient understands that failure to follow these directions may lead to permanent damage to nerve, spinal cord, joint, and other vitals structures leading to permanent disability and pain or

_____.

I have been given an opportunity to ask questions about the condition, alternative anesthesia and treatment, risks of non-treatment, the procedure to be performed, and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.

I, the undersigned, certify that I have read and fully understand this consent form. The physician has disclosed the comparative risks, benefits, and alternatives associated with performing this procedure in the office suite instead of in a hospital.

Fluoroscopy (XRAY) may be utilized for your procedure. Notify the staff immediately if you are or may be pregnant.

Patient is unable to consent because: _____

Name of Relative/Representative authorized to sign for the patient:

_____

Patient (or representative) signature: Date:

Witness: Date: