PAIN & SPINE PHYSICIANS OF SAN ANTONIO

Name:_____

DOB:_____

SS#:_____-_____-_____

Date:_____

2130 Northeast Loop 410, Ste 375 • San Antonio, Texas 78217
8235 S New Braunfels Ave, Ste. 211 • San Antonio, Texas 78235

## Disclosure and Consent for Surgical, Medical, and Diagnostic Procedures

**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 alarm you, it is simply an effort to better inform you so you may give or withhold your consent to the procedure.

**I (we)** voluntarily request **Dr. Narciso Gonzalez** as my physician and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained to me as:

- ❑ **Low Back Pain and Lumbar Radiculopathy**
- ❑ **Neck Pain and Cervical Radiculopathy**
- ❑ **Other: _____**

**I (we)** understand that the following surgical, medical and/or diagnostic procedure(s) are planned for me and **I (we)** voluntarily consent and authorize these procedures:

- ❑ **Epidural Steroid Injection- Cervical/Thoracic/Lumbar**
- ❑ **Trigger Point Injection**
- ❑ **Spinal Cord Stimulator**
- ❑ **Radio Frequency Thermal Coagulation**
- ❑ **Facet Block- Cervical/Thoracic/Lumbar**
- ❑ **Joint Injection- Shoulder/Knee/Hip**
- ❑ **Kyphoplasty**
- ❑ **Ketamine Infusion**
- ❑ _____

**I (we)** understand that my physician may discover other or different conditions that may require additional or different procedures than those planned. **I (we)** authorized my physician and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

_____**I (we)** _____**Do** _____**Do *Not*** consent to the use of blood and blood products as deemed necessary.

_____**I (we)** understand that no warranty or guarantee has been made to result or cure.

_____**I (we)** realize that the following risks and hazards may occur in connection with the particular procedure:
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 (we)** realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, numbness, tingling, failure to reduce pain or worsening of pain, nerve damage including paralysis (inability to move), epidural hematoma (bleeding in or around the spinal canal), seizure, persistent leak of spinal fluid which may require surgery, breathing and/or heart problems including cardiac arrest (heart stops beating), damage to nearby organ or structure, and even death.

_____**I (we)** understand that anesthesia involves additional risks and hazards, but **I (we)** request the use of anesthetics for the relief and protection from pain during the planned and additional procedure**. I (we)** realize the anesthesia may have to be changed possibly without explanation to **me (us). I (we)** understand that certain complications may result from the use of any anesthetic including respiratory problems, memory dysfunction/memory loss, medical necessity to convert to general anesthesia, permanent organ damage, drug reaction, paralysis, brain damage, or even death. Other risks and hazards that my result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth, or eyes.

_____**I (we)** understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

_____**I (we)** have been given the opportunity to ask questions about the condition, alternative anesthesia and treatment, risks of no treatment, the procedures to be used, and the risks and hazards involved, and **I (we)** believe that **I (we)** have sufficient information to sign this informed consent.

KETAMINE PATIENTS:
_____**I** acknowledge that ketamine infusions may cause congenital abnormalities in fetal development and / or other complications of pregnancy. I am taking full responsibility that I am not pregnant at this time.

**I (WE) UNDERSTAND THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM. The surgeon has disclosed the comparative risks, benefits, and alternatives associated with performing this procedure in the ambulatory surgical facility instead of in a hospital.**

**Patient (is a minor_____years of age) AND/OR is unable to consent because:**
_____
_____

_____ _____ _____

**Patient/Relative/Authorized Agent** **Relationship to Patient** **Date/Time**

_____ _____ _____

**Witness** **Translator** **Date/Time**

Vitals-

PS-

%-

NPO-

Driver-

DM-

B/T-

IV-