FLATIRONS SURGERY CENTER
AUTHORIZATION FOR PROCEDURE
#2 – Selective Nerve Root Block/Medial Nerve Block/Radiofrequency Thermocoagulation

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 this procedure.

I voluntarily request Dr. _____ as my physician(s), and such associated technical assistants and other health care providers as he/she may deem necessary, to treat my condition, which has been explained to my satisfaction as (lay terms)

_____

I understand that the following surgical, medical and or diagnostics(s) are planned for me, and I voluntarily consent and authorize these procedures(s) (lay terms): **Injection of local anesthetic and steroid into the specific nerve of the spine causing pain.**

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

I understand that no warranty or guarantee has been made to me as to the result of this procedure or anticipated care.

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 to surgical, medical and/or diagnostic procedures has the potential for infection, blood clots in veins and lung, hemorrhage, allergic reaction, or even death. I also realize the following hazards may occur in connection with this particular procedures:
1. Local pain 2. Bruising/bleeding 3. Infection 4. Drug reaction 5. Numbness 6. Increased pain 7. Paralysis 8. Nerve damage 9. High spinal block.

I understand that anesthesia involves additional risks and hazards, may be used for the relief and protection from pain during the planned and any additional procedures. I realize the anesthesia may have to be changed, possibly without explanation to me. I understand that certain complications may result from the use of any anesthetic, including use of general anesthetics, range from minor discomfort to injury to vocal cords, teeth or eyes. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the procedure(s) to be used, and the risks and hazards involved. I have sufficient information to give this informed consent. My physician has answered my questions to my satisfaction.

I attest that I have explained the risks, benefits and alternatives of this procedure to this patient/representative.

_____ _____
Physician Signature Date

Pregnant: Y N

_____ _____ _____
Signature: Patient/Other Legally Responsible Person Date Relationship

_____ _____ _____
Signature: Witness Date Title