Pain Control Procedure Consent Form

CONSENT TO _____ FOR PAIN CONTROL

1. I authorize the performance upon _____ of the following procedure Lumbar medial branch performed by _____ (physician's name). Hacks

2. I consent to the administration of local anaesthetics, opioids, and/or other medications.

3. I understand that the following, among others, are possible complications or risks of the procedure and that while they are uncommon, they have been reported in the medical literature:

- Failure to relieve pain.
- Exacerbation of pain
- Hypotension (low blood pressure)
- Postdural puncture (spinal) headache Which may require medical therapy
- Persistent area of numbness and/or weakness of the lower extremities.
- Temporary nausea and vomiting
- Breakage of needles, catheters, etc. possibly requiring surgery.
- Haematoma (blood clot) possibly requiring surgery.
- Infection
- Rapid absorption of local anaesthetics causing dizziness and seizures
- Temporary total spinal anesthesia
- Respiratory and/or cardiac arrest (requiring life support systems).

4. I consent to the performance of procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates may consider necessary or advisable in the course of the procedure.

5. The nature and purpose of the procedure, possible alternative methods of treatments, the risks involved and the possibility of complications have been fully explained to me. I understand that no guarantee or assurance has been given by anyone as to the results that may be obtained.

Signature: _____
(Parent/Legal Guardian)

Signature: _____
(Consultant - MCRN)

Date: 15/03/16