Patient Name

DOB:

MR #

Madison Surgery Center
1 S. Park Street-3rd Floor, Madison, WI 53715

CONSENT TO MEDICAL OR SURGICAL PROCEDURES, ANESTHETICS, DIAGNOSTIC RADIOLOGY, AND MEDICAL SERVICES – PAIN

Index to Consent – Treatment/Procedures

Date: _____

Name of the Patient: _____

I request and authorize _____ to perform the procedure(s) described below on the Patient.
I understand that other doctors, residents, and/or advance practice providers may perform some portions of the procedure(s).

☐ **Cervical** ☐ **Thoracic** ☐ **Lumbar** ☐ **Sacral** ☐ **Head** ☐ **Face**

Level: _____

☐ Nerve Block ☐ Medial/Branch Block ☐ Radiofrequency ☐ Cryotherapy
☐ Sympathetic Nerve ☐ Ganglion ☐ Plexus Block ☐ Pain Pump Refill
☐ Joint Injection (Facet/Sacroiliac/Sacrococcygeal/Hip/Knee/Ankle/Shoulder)
☐ Epidural Steroid Injection (Transforaminal/Interlaminar/Caudal) ☐ Other: _____

Needle will be guided into the previously discussed structure(s):

☐ the epidural space ☐ the sympathetic nerves ☐ the sacroiliac or hip joint
☐ the nerve root as it exits the spine ☐ into the disc(s) ☐ near a nerve
☐ the nerves from the facet joint ☐ the facet joint ☐ Other: _____

Planned surgical side (if applicable): Laterality ☐ RIGHT ☐ LEFT ☐ MIDLINE ☐ BILATERAL at _____ Level(s)

Sterile Fluids will be used to (1) confirm correct needle placement and see the target structure, (2) numb the target structure, (3) decrease pain, and (4) lyse nerves.

Other: _____

Risks:

- Increased pain
- Steroid related side effects
- Headache
- Injury to the nerves and muscles at the injection site
- Additional Risks: _____
  _____
  _____
  _____
  _____

Rare Risks:

- Infection (<1 out of 1000)
- Bleeding (risk may be higher if using blood thinning medicine such as Warfarin, aspirin, etc.)
- Loss of function of arm or leg
- Paralysis
- Loss of function of one or more body organ(s)
- Pneumothorax (air outside of the lung)
- Brain damage
- Death

By signing, I agree that (1) I have read this **entire form,** (2) I understand the form and information given to me by the doctor or advance practice provider, (3) I have had the chance to ask questions and have had them answered, and I understood the answers, (4) I consent to the performance of the procedure(s) listed above on the Patient. The risks and benefits of the procedure(s) and other treatment options have been made clear to me. I have also been told what may happen if the Patient does not have the procedure(s).

AUTHORIZING SIGNATURES:

Signature of Patient/Representative _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent / Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other _____

Provider Signature*: _____ Print Provider Name*: _____

Date: _____ Time: _____ Pager# _____

_____ Interpreter or Reader Signature (if applicable)

_____ Print Interpreter or Reader Name

_____ Date Time

_____ Witness Signature**

_____ Print Witness Name

_____ Date Time

* Provider can be Physician or Advance Practice Provider performing the procedure.
** Only required if patient signature not obtained by provider or when telephone consent obtained.

Patient Name

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A doctor or advance practice provider has made clear to me/the Patient:

- what the Patient is having done,
- any concerns,
- other options for treatment,
- possible outcomes,
- what may happen if the Patient is not treated,
- the risks such as severe loss of blood, infection, cardiac arrest, serious injury or death that can happen from both known and unknown causes.

I have been told and I understand and agree that:

1. **Other possible tests/treatments**: Before, during, or after the surgery or procedure(s) listed above, the Patient may have, or the doctor or advance practice provider may find new problems that could not be foreseen. These findings may mean that more or other tests or treatments are needed. I ask that the Patient's doctors/advance practice providers do what they feel is best to diagnose and/or treat the Patient.

2. **Anesthesia/sedation**: The Patient may receive anesthesia and/or sedation from anesthesiologists, residents, anesthetists or from the operating doctors or advance practice providers. The options, risks and benefits of the use of anesthesia and/or sedation have been made clear to me and I consent to its use.

3. **Blood product transfusions**: The Patient may need to have blood products transfused during treatment. The benefits and risks of blood product transfusions have been made clear to me. I also know the risks of not getting blood products. The blood products have been tested for hepatitis, HIV (the cause of AIDS), and other pathogens such as West Nile Virus. Blood products may or may not have been tested for bacteria before the Patient gets them. Testing helps but does not mean that the Patient will not get these or other infections. If the Patient gets blood, there is a chance of allergic reactions. Symptoms may include hives, chills, fever, and nausea. Rarely, people can have rapid damage of the transfused blood, extra fluid in the lung, shock, and more severe reactions. If the Patient's health permits, the Patient may donate the Patient's own blood ahead of time to be used later. Giving one's own blood is not free of risk. It also may not meet all transfusion requirements.

4. **Suspending "no CPR" order**: I understand that it is the practice at this surgery center and the physicians providing my care to temporarily suspend "do not resuscitate" (DNR) orders and I agree to such suspension.

5. **Care providers**: UW Health partners with the University of Wisconsin School of Medicine and Public Health as well as other health care systems and schools. The providers caring for the Patient may be University of Wisconsin School of Medicine and Public Health faculty, residents, fellows, or students in allied health programs.

6. **No guarantee of outcomes**: The practice of medicine, surgery and dentistry is not an exact science. No promises have been made to me about the results of the procedure(s).

7. **Sharing information**: There may be a need to share information about the Patient, such as HIV, tuberculosis, and other diseases with places such as the state health department.

8. **Photos/other sharing**: The procedure(s) may be watched, photographed, filmed, televised, or recorded. This would be done for performance improvement, education, or research.

9. **Tissue or body parts**: Any tissue or body parts removed during the procedure(s) may be kept, thrown away, and/or used for research.