



CAROL SUE CARLSON, MD
Physical Medicine & Rehabilitation

4212 SOUTHTOWNE DRIVE
EAU CLAIRE WI 54701
TEL 715.832.1400

757 LAKELAND DR. STE B
CHIPPEWA FALLS WI 54729
TEL 715.723.8514

CONSENT FOR PAIN MANAGEMENT PROCEDURE

You have a pain problem which has not been relieved by routine treatments. A procedure, specifically an injection is now indicated for further evaluation and diagnosis of your pain. There is no guarantee that a procedure will cure your pain, and in rare cases, it could become worse, even when the procedure is performed in technically a perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, and then determine if further treatment is necessary.

Your physician will explain the details of the procedure listed below. **Tell the physician if you're taking any blood thinner such as Coumadin, Lovenox, Plavix, or Heparin, as these can cause excessive bleeding** and a procedure should not be performed.

Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc. **Benefits** include increased likelihood of correct diagnosis and/or of decrease or elimination of your pain. **Risks** include infection, bleeding, allergic reaction, increased pain; nerve damage involving temporary or permanent pain, numbness, weakness, paralysis or death; air in lung requiring chest tube; tissue, bone or eye damage from steroids. Nerve destruction with Phenol, Botox, Alcohol, or radio-frequency energy has risks of nerve and tissue damage.

Specific risks pertaining to each specific procedure are as follows (patient to initial line of procedure):

____ **Epidural, Facet, Joint, Medial Branch Nerve, Sacroiliac Joint, Selective Nerve Root or Lumbar Sympathetic Injection/Block/Ablation:** Low blood pressure, temporary weakness/numbness arm or leg, headache requiring epidural blood patch, meningitis, infection, paralysis.

____ **Epidural or Spinal Opioid Injection:** Itching, nausea, urinary difficulty, slowed breathing.

____ **Discogram, Intradiscal Steroid Injection or IntraDiscal Electro Thermal Therapy (IDET):** Infection or discitis, nerve injury, leg weakness, leg pain, paralysis.

____ **Stellate Ganglion Block/Ablation:** Hoarseness, difficulty swallowing, seizure, weak and/or numb arm, air in lung, infection.

____ **Trigger point injection, Peripheral Nerve-Neuroma Block, Occipital Nerve Block, Intercostal Nerve Block/Ablation:** Air in lung requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin, pneumonia, chronic pain.

____ **Celiac or Superior Hypogastric Plexus Block/Ablation:** Low blood pressure, internal vessel/organ puncture requiring emergency surgical treatment to repair it, temporary or permanent bowel, bladder, or sexual dysfunction.

____ **Spinal Cord Stimulator Im/explant, Spinal Infusion Pump IM/explant or Refill, Epidural or Spinal Catheter Im/explantation:** Infection requiring hospitalization and removal of stimulator, catheter or pump, meningitis, nerve damage.

____ **Percutaneous Lysis of Epidural Adhesions:** Nerve damage, meningitis, dural puncture, eye hemorrhage, chronic leg weakness.

____ **Myobloc (Botulinum Toxin) Injections:** Nerve or tissue damage, prolonged neuromuscular weakness.

____ **Intra-articular Injection:** Nerve damage, infection, loss of motion.



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The incidence of serious complications listed above requiring treatment is very low (less than 1% in our experience). Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you. It is your decision and right to accept or decline to have the procedure done.

I authorize **Dr. Carol Sue Carlson** to perform the following procedure

I have read or have had read to me the above information, I understand there are risks involved with this procedure, to include rare complications, even death, which may not have been specifically mentioned above. I understand that a sedative may be administered for my comfort during the procedure and that sedatives carry the risk of damage to vital organs, such as the brain, heart, and lungs. The risks have been explained to my satisfaction and I accept them and consent to this procedure.

Patient or His/Her legal guardian

Date

Witness

Physician Declaration: I and/or my assistant have explained the procedure and the pertinent contents of this document to the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed and the patient has consented to the above described procedure.

Physician

Date