



**CAROL SUE CARLSON, MD**  
Interventional Pain & Spine

4212 SOUTHTOWNE DRIVE  
EAU CLAIRE WI 54701  
TEL 715.832.1400

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

Procedure: \_\_\_\_\_ with sedation YES / NO

Date of procedure: \_\_\_\_\_ @ \_\_\_\_\_ am / pm. **Please arrive 60 minutes prior to appointment.**

Date of procedure: \_\_\_\_\_ @ \_\_\_\_\_ am / pm. **Please arrive 60 minutes prior to appointment.**

Date of procedure: \_\_\_\_\_ @ \_\_\_\_\_ am / pm. **Please arrive 60 minutes prior to appointment.**

Follow up appointment after injection (s) \_\_\_\_\_ @ \_\_\_\_\_ am/pm. at Dr Carol Sue Carlson's Chippewa Office.

OakLeaf Surgical Hospital  
3802 W. Oakwood Mall Drive  
Eau Claire, WI 54701  
(715) 831-8130 (715) 839-4121

St. Joseph's Hospital  
2661 County Hwy I  
Chippewa Falls, WI  
54729

Please let us know if you have **ANY** of the following:

\_\_\_\_\_ **ALLERGY TO LATEX, CONTRAST DYE, SHELLFISH OR SEAFOOD**  
\_\_\_\_\_ **HISTORY OF OR CURRENT MRSA/STAPH INFECTION**

#### **IV SEDATION / LOCAL INSTRUCTIONS**

**\*\*\*\* IT IS IMPORTANT TO FOLLOW THESE INSTRUCTIONS FOR THE DAY OF YOUR PROCEDURE!**

1. If you are to receive sedation for the procedure, **DO NOT eat or drink anything** 4 hours prior to the procedure time. Failure to comply with this may result in cancellation of your procedure. If your procedure is to be done with local anesthesia only, there are no dietary restrictions.
2. Take all of your routine medications on the day of the procedure. **Bring a list of your medications and medication allergies with you.**
3. **DO NOT** take any **blood thinner such as Coumadin, Lovenox, Plavix, or Heparin** for 5 days prior to your procedure.
4. **DO NOT** take any **Aspirin, Ibuprofen, Motrin, Advil, Midol, Nuprin, Naproxen, Celebrex, Aleve, Aggrenox, or Excedrin** for 7 days prior to your procedure. Tylenol may be taken.
5. If you are diabetic, test your blood sugar 1 hour prior to coming in for your procedure. If it is 200 or greater, please contact our office immediately.
6. Are you taking an antibiotic at this time? If you are prescribed any antibiotics prior to the date of your procedure, please notify our office as soon as possible.
7. If you should develop a cold, fever, or any other illness prior to your procedure, please call the office.
8. Follow any special instructions your doctor has given you.
9. Arrange for a responsible adult to drive your home. If this is not possible, tell your doctor immediately. You will need a responsible person with you for 24 hours after the procedure.
10. Should you have any questions or concerns, please call the office during normal business hours. Following your procedure, If you develop any unusual pain or symptoms after normal business hours, please contact and/or report to the nearest emergency room.

- ❖ As a service to you, we will pre-certify your procedure with your insurance company and notify you if any problems arise. However, it is your responsibility to call your insurance company to verify your benefits/coverage for this procedure. By signing this paper, you are stating that you have coverage under the above insurance and acknowledging that, if for some reason this procedure is not covered, you will be held responsible for the payment of the procedure.

*I have read the above instructions and agree to follow them.*

\_\_\_\_\_

\_\_\_\_\_

(Signature of Patient or Personal Representative)  
describe relationship Patient)

(Date)

(If Personal Representative,