



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent: Image Guided Ablation (Pain)

This information is given to you so that you can make an informed decision about having an **image guided ablation** with moderate sedation or anesthesia.

Reason and Purpose of the Procedure:

An image guided ablation is a treatment for chronic back and joint pain. The procedure uses imaging (typically x-ray or ultrasound) to guide probes into the nerves. This can provide targeted pain relief.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Less pain
- Improved ability to move
- No incision
- Quick recovery period

General Risk of Procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist or provider will discuss this with you.

Information on Moderate Sedation:

You will be given medicine in an IV to relax you. This medicine will also make you more comfortable. This is called “moderate sedation”. You will feel sleepy. You may even sleep through parts of your procedure. We will monitor your heart rate and your blood pressure. We will also monitor your oxygen level.

If your heart rate, blood pressure or oxygen levels fall outside the normal range, we may give medications to reverse the sedation. We may be unable to reverse the sedation. We may need to support your breathing. Even if you have a NO CODE status:

- You may need intubation to support your breathing.
- You may need medications to support your blood pressure.

We will re-evaluate your medical treatment plan and your NO CODE status when sedation has cleared your body.

Risks of this Procedure:

- **Infection:** you may need medicines or other treatment.
- **Increased pain:** you may need to continue your current pain medications or need more pain medications.
- **Injury to the surrounding area:** these injuries could be temporary or permanent. It depends on what is injured.
- **The procedure may not work:** You may be able to have the procedure again.
- **Temporary or permanent nerve injury:** you may have difficulty using your arms and legs.
- **Paralysis:** In rare cases you may lose the ability to move your arms or legs. This may be permanent or it may improve with time.

Risks Associated with Smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You:

Alternative Treatments:

- Observation
- Medication for pain management
- Open surgery
- Do nothing. You can decide not to have the procedure.

If You Choose Not to Have This Treatment:

- Your pain may get worse.
- Your pain may not improve.

General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure the doctor may need to do more tests or treatment.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.



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By signing this form, I agree:

- I have read this form or had it explained to me in words I can understand.
 - I understand its contents.
 - I have had time to speak with the doctor. My questions have been answered.
 - I want to have this procedure: **Image Guided Ablation (Pain) with anesthesia or moderate sedation** _____
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- I understand that my doctor may ask a partner to do the procedure.
 - I understand that other doctors, including medical residents or other staff may help with procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. If so, please obtain consent for blood/products.

Patient Signature: _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian/POA Healthcare

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back:

Patient shows understanding by stating in his or her own words:

_____ Reason(s) for the treatment/procedure: _____

_____ Area(s) of the body that will be affected: _____

_____ Benefit(s) of the procedure: _____

_____ Risk(s) of the procedure: _____

_____ Alternative(s) to the procedure: _____

OR

_____ Patient elects not to proceed: _____ Date: _____ Time: _____
(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____