Pain Management Consent

To the Patient: You have been told that you should consider medical treatment/surgery. You have the right as a patient to be informed about your condition and the recommended surgical or diagnostic procedure used so you can decide whether to undergo the procedure after knowing the risks and hazards involved.

Patient Name: _____

Authorized Physician: _____

I hereby authorize and direct _____with associates or assistants of his/her choice to perform upon me the following surgical, diagnostic, or medical procedure:

Diagnosis and Condition/Indication:

Benefits: Pain relief

Risk of No Treatment: Persistent pain and functional compromise due to pain (e.g., difficulty sleeping, unable to work, take care of family, or indulge in sexual activity).

Alternatives: Trial of pain medications, physical therapy, and psychological counseling. Avoid painful activities and consult surgery, if appropriate. These alternative methods of treatment have also been explained to me.

Risks: I am advised that though satisfactory results are expected, the possibility and nature of complications cannot be anticipated and therefore, there can be no guarantee, expressed or implied, as to the results. Risks associated with any surgical treatment/procedure include brain damage, quadriplegia (paralysis of all arms and legs), paraplegia (paralysis of both legs), disfiguring scars, death, loss of organ, loss of arm or leg, loss of function of arm or leg, bleeding, breathing difficulties, or infection.

I consent to the administration and use of drugs for anesthesia and/or conscious sedation and other drugs necessary to perform the above-named procedure. The options for anesthesia will be explained to me before administering it. I hereby consent that you may obtain a sample of my blood in case of an accidental exposure of pathogens, a needle stick, etc.

Observers: may be present including employees, medical students, physicians, and attending surgeon.

I have had the opportunity to ask questions about the information in this document and any other questions about the proposed diagnostic test, treatment, or procedure and all questions were answered in a satisfactory manner.

_____ Relationship: _____

Patient Signature/date/time

_____

Witness Signature/date/time

_____

Physician Signature/date/time