Pacific Coast Spine Institute and Pain Center
Maryam Rahbar, M.D.

PATIENTS NAME: _____DATE:_____

INFORMED CONSENT FOR PROCEDURE

DR. MARYAM RAHBAR HAS EXPLAINED THE NATURE AND PURPOSE OF THE PROCEDURE(s)

_____,

AND ALL INDICATED PROCEDURES, AND HAS ANSWERED MY QUESTIONS. I UNDERSTAND THAT THIS PROCEDURE MAY GIVE ME SIGNIFICANT PAIN RELIEF, AND/OR GIVE MY PHYSICIAN VALUABLE INFORMATTION IN DIAGNOSING MY PROBLEM. I FURTHER UNDERSTAND THAT THERE ARE NO GUARANTEES HAVE BEEN MADE OR IMPLIFIED IN REGARDS TO THE EXTENT OF RELIEF I MAY GET FROM THE PROCEDURE.

POSSIBLE SIDE EFFECTS ASSOCIATED WITH THIS PROCEDURE CAN INCLUDE:

>REGIONAL NUMBNESS OR WEAKNESS. WITH CERTAIN PROCEDURES, I MAY HAVE INCREASED NUMBNESS FOR ONE-HALF HOUR TO FOUR HOURS AFTER THE PROCEDURE. FAINTING MAY OCCUR DURING THE PROCEDURE.

>REACTIONS TO MEDICATIONS MAY INCLUDE FLUID RETENTION, MINOR OR TEMPORARY ALLERGIC REACTIONS AND TEMPORARY DECREASE IN BLOOD PRESSURE.

>I MAY HAVE INCREASED PAIN FOR ONE TO SEVERAL DAYS AFTER THE PROCEDURE

>ONE PERCENT OF MY PATIENTS MAY HAVE A HEADACHE AFTER EPIDURAL AND OTHER SPINAL PROCEDURES.

OTHER RARE COMPLICATIONS MAY INCLUDE ALL THEORETICALLY POSSIBLE SIDE-EFFECTS WHICH ARE USUALLY ASSOCIATED WITH LONG -TERM USE, BUT CAN OLSO OCCUR WITH INTERMITTENT INJECTIONS. THESE CAN INCLUDE FLUID -RETENTION, BLOOD SUGAR EVALUATION, BONE AND JOINT DAMAGE, STOMACH IRRITATION, IMMUNE SUPRESSION AND ADRENAL SUPRESSION. SOME OF THESE SIDE EFFECTS MAY NOT BE REVERSIBLE.

OTHER THEORETICAL RISKS RELATED TO ANY INTERVENTIONAL PROCEDURE, INCLUDING NERVE BLOCK PROCEDURES, CAN INCLUDE BLEEDING, INFECTION, ORGAN AND NERVE DAMAGE, PARALYSIS, LOSS OF BOWEL OR BLADDER CONTROL, SEIZURE AND DEATH. THESE COMPLICATIONS RARELY OCCUR BUT THEY CAN HAPPEN WITH ANY INVASIVE PROCEDURE TO ANYONE ANY TIME.

RADIOGRAPHIC CONTRAST AND FLOUROSCOPY X-RAY MAY BE USED DURING MY PROCEDURE TO ASSESS NEEDLE PLACEMENTS. THE RADIOGRAPHIC CONTRAST CAN CAUSE ALLERGIC REACTION IN SOME INDIVIDUALS.

INTRAVENOUS SEDATIVES AND NARCOTICS ARE SIMILAR TO ANESTHETICS. THEY MAY BE USED TO HELP MAKE THE PROCEDURE BETTER TOLERATED. THEIR USE IN RARE CASES MAY CAUSE LOSS OF CONCIOUSNESS, SEDATION, AND LOSS OF REFLEXES, RESPIRATORY FAILURE AND DEATH.

I AGREE TO BE TRANSFERRED TO A SEPARATE MEDICAL FACILITY FOR ADDITIONAL CARE IF MY CONDITION REQUIRES.

I HAVE READ THIS INFORMATION SHEET REGARDING MY PROCEDURE AND HAVE BEEN EXPLAINED ITS CONTENTS. I CONSENT TO THIS PROCEDURE UPON ME BY DOCTOR ANS/OR HIS ASSOCIATES. ADDITIONALLY, I CONSENT TO TRANSFER TO OTHER FACILITIES, USUALLY A MAJOR HOSPITAL, IN CASE OF EMERGENCY SO THAT I MAY BE MORE PROPERLY CARED FOR.

PATIENT SIGNATURE_____DATE_____
PHYSICIANS SIGNATURE_____DATE_____
WITNESS SIGNATURE_____DATE_____

17822 Beach Blvd #101 Huntington Beach, CA 92637 (714) 847-3666 Fax (714) 847-7171