For use by SSR staff only:

Hx of Surgery: ______________________
BT meds: ______________________
Allergies: ______________________

South Sound Radiologists, Inc., P.S.

INFORMED CONSENT
FACET / SACROILIAC JOINT INJECTION

Washington State law guarantees that you have both the right and obligation to make decisions concerning your healthcare. Your clinician (physician or healthcare provider) can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your clinician.

Patient:____ **Patient #:**____________________________________

I hereby authorize Dr.____________________________ and/or such associates or assistants as may be selected by the aforementioned physician to perform a **FACET / SACROILIAC JOINT INJECTION**.

PROCEDURE: Injection of local anesthetic, steroid and possible contrast (x-ray dye) into the facet or sacroiliac joint of the spine through a needle placed into the back or neck using x-ray or CT guidance.

RISKS: I understand all procedures carry some risk. We (your referring clinician and radiologist) would not recommend this procedure unless we believed the advantages far outweighed the disadvantages. However, you must understand and accept the potential risks. The potential risks include, but are not limited to: pain, bleeding, infection, headache, insomnia, nausea, heartburn, fever, allergic/adverse reaction to injected medications, or temporary anesthesia (numbness or weakness). Rare potential risks include vessel, nerve, organ, or spinal cord injury, paralysis, seizure, cardiac or respiratory arrest, disability, and even, death. There is a chance that the needle may not be able to be placed at the desired joint space or result in the desired benefit of pain relief.

BENEFITS: Potential pain relief and/or diagnosis of cause of pain.

ALTERNATIVES TO PROCEDURE: No treatment versus possible medical or surgical treatment.

You always have the right to refuse any procedure at any time. It is your responsibility to inform us if you do not want the procedure or wish to stop during the procedure after it has started. It is also your responsibility to inform us of any prior adverse outcome or reaction to a similar study or x-ray dye/anesthetic.

I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I, therefore, authorize the above-named physician, and his or her assistants or designees, to perform such procedures as in his or her professional judgment are necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of the medical procedure is commenced.

I have viewed and understand the Facet Injection Video. ___________ ________________________________

Date Signature

I certify that I have read this form or have had it read to me, and that I understand its contents.

_____________________________________ _____________________________

Patient/Other Legally Responsible Person Signature Date

_____________________________________ _____________________________

Radiologist Signature Witness