Spine & Sports Surgery Center LLC
429 Llewellyn Ave.   Campbell, CA 95008
(408) 378-6773   Fax: (408) 378-6775

Pre and Post Procedure Guidelines

BEFORE YOUR PROCEDURE:

- Please do NOT take any ASPIRIN or aspirin products like Excedrin for two <u>weeks</u> (7 days) or NSAIDS like Motrin/Ibuprofen/Aleve/Naproxyn for three (3) days before the procedure. If you are on Coumadin/Heparin/Lovenox or Plavix, please let your doctor/staff know immediately as these medications must be discontinued 7-14 days prior to the procedure. If you are uncertain about your medications, please consult with your doctor prior to scheduling your procedure.
- Please do NOT eat or drink anything including gum, candy for 4-6 HOURS PRIOR to the procedure. You should take all your regular medications except for those mentioned above. If you need to take medications, please do so with as little water as possible.
- Please leave all your valuables and/or jewelry at home.
- Please arrive at least 30 minutes before the procedure.
- The procedure will be done in the Surgery Center (left side) in the same building.
- You will be asked to sign a consent form for the procedure and/or anesthesia consent form, and HIPPA form prior to the procedure, so bring your eye glasses if needed.
- YOU CANNOT DRIVE AFTER THE PROCEDURE. Please arrange for a responsible adult to drive you home in advance. No taxi ride will be acceptable.

AFTER YOUR PROCEDURE:

- You will stay in the Recovery Room approximately 5-30 minutes after the procedure for observation, and then be discharged home once you meet the discharge criteria.
- It is not unusual to have increased pain for 1-3 days after the procedure. At home, apply ice packs over the area of injection, 20 minutes at a time, three times a day for one or two days following the procedure as needed. This can help relieve the pain/swelling at the injection sites.
- Avoid strenuous exercise – even if you feel great – for at least one week.
- If you are currently in physical therapy, you may start 5 days after the procedure. Have the therapist call your doctor regarding any questions.
- You may resume your current pain medication/s after the procedure.
- Follow-up appointment will be necessary in approximately 1-2 weeks. However, call your physician or staff for any related problems at any time.
- You may slowly progress to your normal diet after the procedure.
- Call your doctor for temperatures greater than 101, or if there is persistent redness/swelling at injection sites, persistent new weakness/numbness, loss of control of bowel/bladder function, persistent dizziness/ drowsiness, blurry vision, persistent headache, or any serious concerns related to the procedure.

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Informed Consent for Procedure

In compliance with NRS 41A.110

You have a pain problem which has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatment of your pain. There is **no guarantee** that this procedure will cure your pain, and in rare cases, it could become worse, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, then determine if further treatment is necessary.

Please notify the Physician immediately if you are taking any blood thinners such as Coumadin, Lovenox, Heparin, Aspirin, or Plavix as these medications can cause excessive bleeding.

Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc.

Benefits include increased likelihood of correct diagnosis and/or decrease and/or elimination of your pain.

Risks include infection, bleeding, allergic reaction, increased pain; nerve damage involving temporary or permanent pain, numbness, weakness, paralysis or death; air in lung requiring chest tube; tissue, bone or eye damage from steroids. Nerve destruction with phenol, Botox, alcohol, or radiofrequency energy has risks of nerve and tissue damage. The incidence of serious complications listed above requiring treatment is very low (less than 1% in our experience). Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done.

Specific risks pertaining to each specific procedure are as follows (patient to initial line of procedure):

_______Epidural, Facet Joint, Medial Branch Nerve, Sacroiliac Joint, Selective Nerve Root or Lumbar Sympathetic Injection/Block/Ablation: Low blood pressure, temporary weak/numb arm or leg, headache requiring epidural blood patch.
_______Epidural or Spinal Opioid Injection: Itching, nausea, urinary difficulty, slowed breathing.
_______Discogram, Intradiscal Steroid Injection, Nucleoplasty or IntraDiscal ElectroThermal Therapy (IDET): Infection or discitis.
_______Stellate Ganglion Block/Ablation: Hoarseness, difficulty swallowing, seizure, weak and/or numb arm, air in lung.
_______Trigger Point Injection, Peripheral Nerve-Neuroma Block, Occipital Nerve Block, Intercostal Nerve Block /Ablation: Air in lung requiring chest tube in a hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin.
_______Celiac or Superior Hypogastric Plexus Block/Ablation: Low blood pressure, internal vessel/organ puncture requiring emergency surgical treatment to repair it; temporary or permanent bowel, bladder, or sexual dysfunction.
_______Spinal Cord Stimulator Im/explant, Spinal Infusion Pump Im/explant or Refill, Epidural or Spinal Catheter Im/explantation: Infection requiring hospitalization and removal of stimulator, catheter or pump; meningitis, nerve damage.
_______Percutaneous Lysis of Epidural Adhesions: Nerve damage, meningitis, dural puncture, eye hemorrhage.
_______Myobloc (Botulinum Toxin) Injection: Nerve or tissue damage, prolonged neuromuscular weakness.
_______Percutaneous Neuromodulation Therapy (PNT): Infection, tissue or nerve damage, air in lung.

I hereby authorize and direct the above referenced Physician and designated assistants as may be selected by the Physician to perform the stated procedure above on this day. Your signature on this form indicates that you have read and understood the information provided with this procedure, to include rare complications, even death, which may not have been specifically mentioned above. The Alternatives, Benefits, and Risks have been adequately explained to my satisfaction with all my questions answered. I accept these conditions and authorize and consent to this procedure with no warranty or guarantee has been made as to the outcome.

- *I have received a copy of the patient's rights and responsibilities prior to the surgery date. I further acknowledge that SSSC does not honor advanced directives and that I will be resuscitated with all available means in case of a medical emergency.*
- *I am aware that SSSC is a physician owned surgery center and I have the right to know the name (s) of the owner (s).*

_________________________________ Date:

Patient Signature/Guardian Signature (Indication Relationship) Time:

o Patient is unable to sign, Reason: ____

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