

Please read this form entirely as it contains information to assist you in making a decision to have a specific treatment. There are risks and complications that may result from this treatment, they are rare, but do exist and you must be aware of them. It is most important that you understand this information so please discuss any questions with the provider. We also encourage you to seek further information via reputable online resources or elsewhere to make sure you are comfortable with the risks and benefits of this treatment. We want you to have clear information about your choice to have an off-label treatment of Triamcinolone, Dexamethasone, and B12 individual injections to relieve chronic symptoms.

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by your provider. For the purpose of this agreement the use of the word “provider” is defined to include not only the Nurse Practitioner but also the provider’s authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my provider to treat my condition with a mixture of Triamcinolone, Dexamethasone, and B12 individual injections. It has been explained to me that these medication(s), can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PROVIDER PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS “OFF-LABEL” PRESCRIBING). MY PROVIDER WILL EXPLAIN THE TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I may undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from care.

FOR FEMALE PATIENTS: To the best of my knowledge, I am NOT pregnant. I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my provider immediately if I become pregnant. If I am pregnant or am uncertain, I WILL NOTIFY MY PROVIDER IMMEDIATELY.

ALTERNATIVES: The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

GOAL OF TREATMENT: The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life as well as improve my mental health. Discussed limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my provider of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

GUARANTEES: I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and

procedure(s), and I believe that I have sufficient information to give this informed consent. *****If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my provider may try alternative medication(s) or may taper me off all medication(s). I will not hold my provider liable for problems caused by the discontinuance of medication(s).

PARTICIPATION: I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the treatment plan as recommended by my provider to achieve increased function and improved quality of life. When chronic pain and mental health disorders occur together, it is important to treat both conditions. Some treatments and approaches may help both mental health and pain conditions. Medications can also be useful in treating both conditions. Lifestyle changes, such as exercise, good nutrition and sufficient sleep, can also be helpful for both managing pain and improving mental health symptoms.

RELEASE: I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am obtaining injections, since the use of other medication(s) may cause harm. I hereby give my provider permission to discuss all diagnostic and treatment details with my other provider(s) and pharmacist(s) regarding my use of medications prescribed by my other provider(s).

MEDICATION INFORMATION: The combination of Dexamethasone, Triamcinolone, and B12 IM injections have been wildly used to improve energy, cell health, reduce pain and inflammation rapidly, speed healing of muscles and joints, boost strength and stamina, improve mobility and range of motion, enhance mental focus and mood, increase energy and vitality despite lacking scientific evidence or FDA approval. Potential side effects and long-term safety also remain unknown.

COMPLETED STUDIES: A 2018 study followed 28 patients who got this injection for chronic shoulder pain- After 6 months, they reported less pain and better range of motion. A 2015 study gave injections to 27 patients with elbow tendonitis- After 24 weeks, they had significantly lower pain scores. ****both of these studies were small and did not include control groups for comparison.

POTENTIAL INDICATIONS: Providers of the Dexamethasone, Triamcinolone, and B12 IM injection claim it can help treat a wide array of orthopedic conditions, including: arthritis, tendonitis, tendon tears, bursitis, nerve pain. However, there is currently no rigorous research demonstrating the efficacy of the shot for these specific problems. This specific mixture of medication is individually approved, however is not approved by the Food and Drug Administration (FDA) in combination.

MEDICATION CLASS: Steroids (Dexamethasone, Triamcinolone, and B12 IM injections) the name used to describe a group of drugs correctly known as corticosteroids. Steroids are used to treat inflammation. Steroids can be injected directly into tissue such as a bursa or joint, or intramuscular for a systemic effect.

SIDE EFFECTS: Possible side effects include allergic reaction, immediate pain at the injection site, transient increase in pain at the injection site for several days, infection, bleeding, bruising, localized thinning or depigmentation of the skin, thinning of subcutaneous fat resulting in dimpling, and weakening of tendons. Steroids may cause a transient increase in blood sugar. Increased risk of contracting infections including COVID-19. Possible psychological effects of all steroids can occasionally cause mental health problems although this is usually associated with high doses however include Feeling depressed, including thinking about suicide, feeling high (mania), or moods that go up and down, feeling anxious, or having problems sleeping, difficulty in thinking or being confused and losing your memory, Feeling, seeing or hearing things which do not exist. Other possible significant side effects Avascular Necrosis (AVN) of the hip. This is where the “ball” component of the ball and socket joint that is the hip is flattened. This can lead to pain and arthritis. Pain and skin colour changes (hypopigmentation) at site of injection. Sterile abscess at site of injection. Dimpling of skin caused by loss of fat under the skin at injection site. This can cause an unsightly dimple and scar on the skin of your buttock which may occur anywhere from days to months after the injection and may be permanent. Other possible side effects general to Steroids: Mood changes; Indigestion, stomach pain, stomach ulcers, bloating, weight gain, pancreatitis; Eye problems including glaucoma and cataracts; Fungal infections e.g thrush; Osteoporosis (thinner bones); Reduction in the body’s overall ability to respond to major stress resulting from serious injuries.

RISKS: It is possible that if you were to get an infection within a few weeks of having an injection that it would be a worse/more severe illness/episode than would otherwise be the case. Little or no response to vaccinations as a direct result of immunosuppression caused by steroids. It is therefore advised that steroids are NOT administered 4 weeks either side of any vaccination. Rare complications include avascular necrosis (bone death), steroid arthropathy / damage to the joint, damage to surrounding nerves, and systemic reactions such as palpitations, hot flashes,

adrenal suppression, irregular menstrual bleeding, or mood changes including anxiety, insomnia or psychosis. The above listed risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization and/or extended outpatient therapy to permit adequate treatment.

I UNDERSTAND THAT MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES ARE OFFERED REGARDING MY EXPECTED RESULTS. I AM AWARE THAT IT IS POSSIBLE THAT THIS TREATMENT WILL NOT WORK FOR ME.

I can confirm that it has been 4 weeks or more since completing a vaccination or I will not be having a vaccine in the next 4 weeks as I am aware that the injection may substantially reduce the effectiveness of vaccination and understand that delaying my vaccine may increase my chance of contracting a virus.

I have read the foregoing information, it has been explained, and I understand it. All of my questions have been answered. By executing this form, I am indicating that I have no questions whatsoever and I give my full informed consent to have the Dexamethasone, Triamcinolone, and B12 IM injection performed.

I accept these risks and by signing this consent form, provide my informed consent to proceed with having the injection administered.

I accept that the Injection is not a cure for chronic pain/inflammation and that symptom improvement is not guaranteed.



Jesus Shot®

I understand and acknowledge that I am voluntarily consenting to receive IV and IM administered steroid medication (such as cortisone, dexamethasone, methylprednisolone, prednisone, or others). Steroids are used to reduce inflammation, swelling, and pain in certain medical conditions. Steroids can have the potential benefits: Relief of pain or inflammation, Improved function and mobility, reduction in swelling and irritation

I acknowledge that, although Steroid Therapy is generally safe, there are inherent risks and potential side effects associated with this procedure. These risks include, but are not limited to:

- Infection at the site of the needle insertion
- Bruising or collection of blood at the injection site
- Nausea, dizziness or fainting spells
- Inflammation at the injection site may occur, leading to pain, redness, and swelling
- localized thinning or depigmentation of the skin, thinning of subcutaneous fat resulting in dimpling, and weakening of tendons.
- Although rare, allergic reactions can occur, leading to rashes, itching, swelling, difficulty breathing, and in rare instances, cardiac arrest, stroke
- While extremely rare, there is a remote possibility of nerve damage at the injection site
- A transient increase in blood sugar
- Rare complications include avascular necrosis (bone death), steroid arthropathy/ damage to the joint, damage to surrounding nerves, systemic reactions such as palpitations, hot flashes, adrenal suppression, irregular menstrual bleeding, or mood changes including anxiety, insomnia and or psychosis
- Serious risk, extremely rare but possible include stroke, heart attack, cardiovascular complications, death

The above listed risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization and/or extended outpatient therapy to permit adequate treatment and possible death. I understand that medicine is not an exact science and that no guarantees are offered regarding my expected results. I am aware that it is possible that this treatment will not work for me. I have read the foregoing information, it has been explained, and I understand it. All of my questions have been answered. By executing this form, I am indicating that I have no questions whatsoever and I give my full informed consent to have Steroid injection performed.

By signing below, I confirm that I have been fully informed of the potential risks, benefits, and complications and I voluntarily agree to undergo the treatment. I release the administering provider, clinic and Jesus Shot LLC from any liability or claims arising from the treatment.

Patient Signature

Print Legal Patient Name

Date of Signature