



360 SPINE CARE

a Division of Vascular and Interventional Radiology
of Community Care Physicians

Leading the way to better spine health.

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Ronny Kafiluddi, MD, PhD, FIPP

CONSENT FOR PAIN MANAGEMENT TREATMENT

INTRODUCTION:

Dr. Ronny Kafiluddi has requested that you undergo the following procedure known as

_____.

This procedure is being performed to further evaluate and/or treat your diagnosis of

_____.

We are asking you to read and sign this form so that we can be sure you understand the procedure and potential benefits, along with the associated potential risks, complications, alternatives, the likelihood of achieving the goals, and the recuperative process. Please ask questions about anything on this form that you do not understand.

PROCEDURE:

This procedure involves the placement of a fine needle through your skin and into a designated location. Some numbing medicine will be injected in the skin over the site that will be used before the needle is inserted.

Following insertion, the needle may be guided into position with a camera, using either x-rays (fluoroscopy or CT), sound waves (ultrasound), or magnetic signals (MRI). It may be necessary to make more than one pass of the needle to achieve the proper location.

At the completion of the procedure, the needle will be removed, and pressure will be applied to the insertion site until possible bleeding has stopped.

RISKS:

Risks associated with the procedure include, but are not limited to, pain or discomfort at the needle insertion site, bleeding at the site, epidural hematoma, infection (spinal and/or skin), increased pain, failure to give desired therapeutic effect, allergic reaction, nerve damage, paralysis, syncope (fainting), headache, and stroke.

Risks associated with the x-ray contrast material include an allergic reaction and reduced kidney function. If pregnant, risks to you and/or the unborn fetus.

Risks associated with local anesthetics are drowsiness, dizziness, confusion, ringing in the ears, blurred vision, metallic taste and an irregular heart rate.

CONSENT FOR PAIN MANAGEMENT TREATMENT (continued)

ALTERNATIVES:

There may be other procedures that can be performed to further evaluate and/or treat your condition. If you are unsure about having an interventional radiology procedure performed, please discuss these other alternatives with your physician.

AGREEMENT:

The information on this form was explained to me by Dr. Ronny Kafiluddi. I understand the information and I have had the opportunity to ask any other questions I might have about the procedure, the reasons it is being performed, the associated risks, and the alternatives to the procedure. I agree to undergo the procedure to be performed by Dr. Ronny Kafiluddi and his/her associates, assistants, and appropriate personnel, and accept the risks. I also agree that CCP staff may participate in significant tasks that are part of the procedure.

Patient Name: _____

DOB: _____

Signature: _____ Date/Time: _____

Witness Name: _____

Witness Signature: _____ Date/Time: _____

Physician Signature: _____ Date/Time: _____

Please initial each line acknowledging you have received each of the following:

_____ Pre Procedure Instructions

_____ Post Procedure Instructions