



DR. MICHAEL WILLENS
ADVANCED PAIN MANAGEMENT CLINIC, LLC
3003 CLAIRE LANE, BUILDING 100
JACKSONVILLE, FL 32223

STANDARD INFORMED CONSENT AND PROCEDURE FORM

I hereby authorize Dr. Michael S. Willens (“Doctor”) and whomever he may designate as his assistant to perform upon me the following diagnostic and/or invasive and/or surgical procedure(s):

- | | | |
|---|---|---|
| <input type="checkbox"/> Suprascapular Nerve Block | <input type="checkbox"/> Superficial C. Plexus Block | <input type="checkbox"/> Osteopathic Manipulation Treatment |
| <input type="checkbox"/> Trigger Point Injection(s) | <input type="checkbox"/> Cluneal Nerve Block | <input type="checkbox"/> Sciatic Nerve Block |
| <input type="checkbox"/> Cervical Epidural Steroid | <input type="checkbox"/> Thoracic Epidural Steroid | <input type="checkbox"/> Lumbar Epidural Steroid |
| <input type="checkbox"/> Sacroiliac Joint Injection | <input type="checkbox"/> Bilateral Lumbar Facets | <input type="checkbox"/> Bilateral Cervical Facets |
| <input type="checkbox"/> Occipital Nerve Block(s) | <input type="checkbox"/> Joint Injection / Aspiration | <input type="checkbox"/> Radiofrequency Ablation _____ |
| <input type="checkbox"/> Other _____ | | |

If any unforeseen condition arises in the course of these designated procedures, including, but not limited to, intramuscular and intravenous procedures, injections or aspirations and/or surgeries or any other procedures which may be described or required, calling in the Doctor’s judgment for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable, under the circumstances.

I consent to the above diagnosis and treatment plan after having been advised of the alternate plans of diagnosis and treatment available, the known material risks of the diagnosis and treatment to be used and the consequences if these diagnostic and treatment procedures were to be withheld or refused.

I am informed and fully understand that inherent in any type of pain management treatment or procedures, invasive diagnostic and/or treatment procedure and/or surgery are certain unavoidable complications. In pain management, the most common of these complications include post-procedure bleeding and post-operative infection, swelling or bruising and discomfort. Other complications include injury to adjacent tissues, nerve injury (i.e., numbness). I understand that any of these complications may require additional surgery or procedure to correct. I further understand there may be scarring and there may be need for additional treatment.

I further consent to the administration of various types of local anesthesia, antibiotics, analgesics, numbing medications or any other drugs that may be deemed necessary in my case, and understand that there is an element of risk inherent in the administration of any drug or anesthesia under all circumstances. This risk includes adverse drug reaction (e.g., allergic reactions), cardiac arrest, aspiration and thrombophlebitis (e.g., irritation and swelling of a vein), pain, discoloration and injury to blood vessels, skin, subcutaneous tissue and nerves, including hyperallergic reactions, ranging from discomfort, pain and **paralysis to death**, which may be caused by injections of any medications or drugs, and the procedure itself. Every medicine has side effects. This has been explained to me to my complete satisfaction and I have no unanswered questions with respect to proceeding and going forward with my treatment.

I also am informed and fully understand that if I am to receive local anesthesia and other pain management agents, I will not operate a motor vehicle or operate any dangerous machinery after such administration and I will be accompanied to and from the office by a responsible adult, as necessary for the procedure, unless the local anesthesia is unrelated to cognitive and motor functions.

A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.



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I realize that, in spite of the possible complications, my contemplated diagnostic procedure and/or surgery/treatment is necessary and desired by me. I am aware the practice of pain management is not an exact science and I acknowledge no guarantees have been made to me concerning the results of the procedure, operation or treatment. I specifically and fully consent to the above procedure(s) based upon my analysis of the risks, benefits and alternatives, all of which have been explained to me to my complete understanding and satisfaction.

I realize that it is mandatory that I give as accurate, current and complete medical and personal history as possible, and to follow any and all instructions as directed by my Doctor and his staff.

Patient: _____ / _____
(First) (Middle) (Last) (DOB)

Signature of Patient Date

Signature of Parent/Guardian Date

Signature of Witness Date

POST-PROCEDURE INSTRUCTIONS

Pain Management procedures, based upon anesthesiology, provide for the use of various medicines to treat pain, including medications which will have side effects. The procedures themselves are not without risk and the patient must read the following instructions carefully and follow these instructions. In any case where there is a medical problem, contact the physician at once. In the event of an emergency, contact 9-1-1, immediately.

1. Bleeding: A band-aid or gauze has been placed on the area of the procedure as a pressure bandage to control bleeding. Do not remove this bandage for one (1) hour. Changing the dressing frequently can actually prolong the bleeding. Place saturated gauze or band-aid in proper receptacle.
2. Pain: Take your pain medication as soon as possible, before the local anesthetic wears off. Pain medication on an empty stomach may cause nausea. A glass of milk will help protect your stomach. Tylenol or Ibuprofen medication may be substituted for the prescribed pain pills when the severity subsides, in the event pain medication has been prescribed.
3. Swelling: It is to be expected during the 24 hours after the procedure. Ice packs placed over the area of the surgery, procedure or injection will help minimize swelling. Alternate the ice pack ten (10) minutes on and ten (10) minutes off for the first four (4) to six (6) hours after the procedure, as necessary.
4. In case of extreme pain, uncontrollable bleeding or anything unusual, call the Doctor. If you call outside of office hours, the answering service will contact the Doctor and he will call you back.
5. Sutures, if present, will be removed at your post-procedure, which will be scheduled within four (4) to seven (7) days after surgery.