Sacroiliac Joint Injection Consent Form

Washington State Law guarantees that you have both the right and obligation to make decisions concerning your healthcare. This form indicates your acceptance of treatment recommended by your healthcare provider.

I hereby authorize_____and/or associates to treat the following conditions which have been explained to me: _____

The following procedures have been explained to me by my provider:

Right ☐ Left ☐ Bilateral ☐ Sacroiliac Joint Injection ☐

Sacroiliac joint injections are used to diagnose and treat the source of your pain. The duration of relief is dependent on the patient. Benefits may include, diagnosis of the source of your pain, decreased pain and increased function in your daily life. Alternatives to this procedure include, but are not limited to physical therapy, acupuncture, chiropractic care, massage therapy and medications.

In general, risks of this procedure include: Infection, bleeding, swelling or scarring at the procedure site; Damage to near-by structures, including nerves (i.e. temporary or permanent nerve damage resulting in weakness, numbness or increased pain); Allergic reactions or systemic/local effects of medications including those used for sedation, and allergic reactions to equipment or cleaning supplies used during the procedure. Other serious complications, though rare, are possible. These include but are not limited to, post-dural puncture headache, bowel or bladder dysfunction, permanent or partial disability, exacerbation of pain or disability and death, which may be associated with the performance of any procedure. **Please read and initial to confirm the following:**

_____ **I certify** that my provider has informed me of the nature and character of the proposed treatment, the anticipated benefits of that treatment, the possible alternative treatments, and the possible risks and complications involved in this treatment. I acknowledge that no warranty or guarantee of outcome has been made to me and other complications may arise.

_____ **I recognize** that it is my responsibility to ensure my provider is aware of my past medical history, especially the use of blood thinners, including aspirin; diagnosis of diabetes or blood sugar issues; and allergies to medications or equipment, including antibiotics, latex, iodine, contrast agents (dyes), chlorhexidine, adhesives or sensitivities to steroids or local anesthetics.

_____ **I recognize** that unforeseen conditions may necessitate additional or different procedures than those set forth above. I therefore authorize my physician and/or associates to perform such procedures as are in the exercise of his or her judgment deemed to be medically necessary. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my provider at the time that my treatment is commenced.

_____ **I certify** that I have read and understand the contents of this consent or have had them read to me. My questions have been answered to my satisfaction. I consent to this treatment, as well as to the administration of local anesthesia, intravenous procedural sedation, and to the administration of those medications deemed medically indicated and appropriate by my physician/provider, as indicated by my signature below.

PATIENT/ GUARDIAN SIGNATURE (Printed):_____

PATIENT/ GUARDIAN SIGNATURE:_____ Date/Time:_____

PROVIDER SIGNATURE:_____ Date/Time:_____