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**INFORMED CONSENT FOR PAIN BLOCK INJECTION & ANESTHESIA  
Scott T. Boyd M.D. & Greg N. Arends M.D.**

This procedure will involve placing a needle into the appropriate area and then depositing medication into that area in order to treat or diagnose a painful condition. Such procedures can be uncomfortable at times.

This procedure is not mandatory. Rather, they are proposed treatment options you have selected. An alternative to such treatment might include doing nothing or treating the painful condition with an alternative form of therapy such as physical therapy, medications, massage therapy, acupuncture, or others. **Please note that cancellations must be made 24 hours in advance or a \$150.00 no show appointment fee will be charged.**

There are risks associated with undergoing this procedure and with receiving any medications. Such risks include, but are not limited to the following:

1. Reactions to medications: This may be a minor reaction such as local skin irritation or a rash. Severe reactions such as anaphylaxis, low blood pressure, nausea, seizures, cardiac toxicity, or temporary respiratory failure are rare but can occur.
2. It is possible that you will experience temporary numbness of a limb or area that may last for several hours. Permanent nerve damage is very rare but possible.
3. You may experience increased pain for several days to a week as a result of the procedure.
4. With any injection there is a risk of infection or bleeding. Infection and/or bleeding are exceedingly rare but can range from minor to life threatening.
5. For certain procedures such as epidural blocks or spinals, there is a risk of experiencing a severe headache.

Patients are instructed not to eat or drink six hours prior to the injection, arrange a ride home from the outpatient facility, and discontinue anticoagulants three to seven days prior to injection as instructed by their physician.

**Patient consent:**

**I have read and fully understand this consent form. Additionally, I have had the opportunity to discuss these issues with my physician. By my signature, I consent to the procedure and/or sedation and I accept the accompanying risks. I also consent to undergo any emergency treatments that might be required in the event of a complication.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_