Indian Society for Study of Pain

ISSP UNIFORM CONSENT FORM FOR INTERVENTIONAL PAIN PROCEDURES

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Applicable: All over India

www.issp-pain.org
INFORMED CONSENT FOR PAIN INTERVENTIONS

NAME OF PATIENT: __________________________ DATE: ________________

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended diagnostic or therapeutic interventional procedure under real time image guidance or drug therapy to be used, so that you may make the informed decision whether or not to ACCEPT THE INTERVENTION OR 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.

You have a pain problem, which has not been relieved by conservative treatments. An interventional procedure is now indicated for further diagnosis and/or treatment of your pain. There is no guarantee that a procedure will cure your pain, and in rare cases, it could become worse, even when the procedure is performed in technically a perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, and then determine if further treatment is necessary.

I. Nature of the illness

a. ____________________________
b. ____________________________
c. ____________________________

II. Nature of the proposed treatment/s or procedure/s

a. ____________________________
b. ____________________________

III. Alternative procedure/s or treatment/s

a. ____________________________
b. ____________________________
INFORMED CONSENT FOR PAIN INTERVENTIONS

IV. Risks involved with Interventional procedures include infection, bleeding, allergic reaction, increased pain; nerve damage, numbness, weakness, paralysis or death. Specific risks pertaining to the proposed intervention are:

a. 

b. 

c. 

V. Benefits involved in both the proposed procedure

a. 

b. 

c. 

d. 

e. 

VI. Potential risks of not receiving the treatment:

a. 

b. 

VII. Relative chances of success or failure of procedure/s:

a. 

b. 

CONSENT TO TREATMENT AND/OR DRUG THERAPY:

I hereby authorize and give my voluntary consent for my physician to perform the proposed intervention and/or to administer or write prescription(s) for controlled drugs (medications) as an element in the treatment of my pain, which may include steroids and/or opioids/narcotic drugs. These medications, like other medicines used in medical practice, may produce side effects or adverse reactions. This also includes the use of medications for purpose different than what have been approved by Drug Company but the research and evidence has shown beneficial effects. This is referred to as "off-label" use.

I understand that no warranty or guarantee has been made to me as to the results of any medications or interventional procedure to cure my condition.
# INFORMED CONSENT FOR PAIN INTERVENTIONS

## Pre Procedure Check List

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td>Is this your first intervention for this problem?</td>
<td>If NO, how many have you had in the last 12 months? ___________</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Are you diabetic?</td>
<td>If YES, is your blood sugar currently well controlled? Y / N</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Do you take insulin?</td>
<td>Please list your diabetic medications (not doses): ________________</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Are you taking any blood thinning medications: Clopidogrel/Warfarin, etc?</td>
<td>If YES, what date did you last take the medication? ___________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please name all the medicines (not doses) you are currently taking:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Are you suffering from any kidney/ heart or Liver problems?</td>
<td>__________ __________ __________</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Do you currently have any active infection or fever? If YES, what?</td>
<td>________________</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Are you allergic to IV contrast or any other drugs? If YES, what?</td>
<td>__________ __________ __________ __________</td>
</tr>
<tr>
<td>Y</td>
<td>N</td>
<td>Female Patients: Is there any chance you could be pregnant?</td>
<td>IF YES, Please notify prior to the procedure.</td>
</tr>
</tbody>
</table>

Patient Signature (Guardian signature, if patient is minor)  
__________________________________________________________________________

Witness 1  
__________________________________________________________________________

Witness 2  
__________________________________________________________________________

Physician Signature  
__________________________________________________________________________
INFORMED CONSENT FOR PAIN INTERVENTIONS

Special interest group (SIG) has been formed by ISSP and the committee comprises of

a) Chairman: Dr. Pankaj N Surange
b) Vice Chair: Dr. Rajeev Harshe
c) Members:
   a. Dr. AnuragAgarwal
   b. Dr. GauravGoyal
   c. Dr. Pavan Kumar Bichal
   d. Dr. Manish Raj
   e. Dr. Nazir Ahmad
   f. Dr. Sweta Salgaonkar
   g. Dr. RohitLahori
   h. Dr. AshishChakrborty