NEURO SPINE AND HEADACHE

PAIN MANAGEMENT CENTER

Consent Form

For Stopping Blood Thinners and Other NSAIDS

Prior to Procedure or Surgery

PATIENT NAME: _____ D.O.B.:_____

1. STOP taking blood thinners and NSAIDS for the amount of days indicated.

Deje de tomar anticoagulantes y NSAIDS por la cantidad de días indicados.

a. Ibuprofen (7 days)
b. Advil (7 days)
c. Excedrin (7 days)
d. Naprosyn (7 days)
e. Meloxicam (7 days)
f. Midol (7 days)
g. Diclofenac *Tablet/Gel* (7 days)
h. Celebrex (7 days)
i. Fish Oil (15 days)
j. Vitamin E (15 days)
k. Aspirin (7 days)
l. rivaroxaban (xarelto) (7 days)
m. dabigatran (pradaxa) (7 days)
n. apixaban (eliquis) (7 days)
o. heparin (7 day)
p. warfarin (coumadin) (7 days)
q. ticagrelor (brilinta) (7 days)
r. Aggrenox (7 days)
s. Plavix (Clopidogrel) (7 days)
t. Cymbalta (Duloxetine) (15 days)
u. Flax seed (7 days)
v. Chia Seed (7 days)
w. Arnica (7 days)
y. Cilostazol (7 days)
z. Voltaren gel (7 days)

Any other anti-inflammatory or blood thinners medications

***Please notify if allergic to Iodine /Shellfish/Cortisone**

2. If you are taking Coumadin / Si está tomando coumadin:
   Please consult your primary care doctor and get clearance from your doctor prior to the procedure or surgery. INR must be checked 72 and 24 hours prior to procedure.
   Consulte a su médico primaria y obtenga autorización de su médico antes de procedimiento o cirugía. El INR debe ser revisado 72 y 24 horas antes del procedimiento o cirugía.
3. Be aware that Depo-Medrol will increase your blood sugar levels.
   Tener quidado si es diabetico por el medicamento Depo-Medrol incrementar su nivel de azucar en la sangre.
4. Notify us if you are allergic to iodine or contrast.
   Notificarnos si usted es alérgico al yodo o contraste.
5. Notify us if you are on any antibiotics.
   Notificarnos si usted en algún antibiótico.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS NAME: _____

WITNESS SIGNATURE: _____

Bed # _____

THE NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
SAYED MONIS, M.D.
195 West Legion Road, Brawley, CA 92227
Tel (760) 351-8669 Fax (760) 351-8894

INFORMED CONSENT

PATIENT: _____ DATE: _____
D.O.B.: _____
Permission is hereby granted to perform the following procedure: Time out:

_____

_____

_____

An informed consent requires that common complications are made known to you. Most of these are not expected to occur. All must be considered. The law requires that you are informed; that you are given other options/alternatives and have a right to refuse the procedure.

1. Edema (swelling): This may occur at the site of injection. Usually non-life threatening, but may become life threatening.
2. Infection: This may occur at the site of injection. Usually non-life threatening, but may become life threatening.
3. Scarring: May or may not occur.
4. Adverse reaction to medication: This could be mild. Usually non-life threatening, but may become life threatening. May or may not require hospitalization.
5. You have a right to deny the procedure and an alternate treatment may be provided to you.
6. Cervical Epidural/Adhesiolysis can result in quadriplegic paralysis of all four extremities or paralysis from the neck down.
7. Lumbar Epidural/Adhesiolysis/Selective Nerve Root Block can result in paralysis of bilateral lower extremities or paralysis from the waist down.
8. Alternate Treatment: _____
   _____
9. Hospital Admission: I understand that treatment of any unusual or serious complication as a result of the procedure is not covered by this visit.
10. I _____ agree to accept the policies mentioned above and with the procedure done by Sayed Monis, M.D. or his staff under his supervision.

Patient Signature: _____ Date: _____

Witness name: _____

Witness Signature: _____