NEW JERSEY SPINE AND PAIN INSTITUTE, LLC

DR. JOSEPH IBRAHIM, M.D
19 EAST 27TH STREET, BAYONNE, NJ 07002
PHONE# (201) 436-0033
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CONSENT FOR SPECIAL PROCEDURE(S)

DATE OF PROCEDURE(S): _____ TIME IN:_____ TIME OUT:_____

[ ]_____ Epidural Steroid Injection(s) with or without contrast
[ ] Facet/Medial Branch Nerve Blocks _____
[ ] Radiofrequency Ablation of the Medial Branch/Dorsal Rami Nerves_____
[ ] Sacral iliac Joint(s) Arthrogram and Steroid Injection
[ ] Selective Nerve Root Block/ Transforaminal Epidural
[ ] Other: _____

I, _____ (DOB_____), acknowledge that my doctor and / or staff have explain to me that the diagnostic or treatment procedure(s) checked above. My doctor and/ or staff have explained the risks of the procedure(s), advised of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated.

It has been explained to me that all forms of diagnostic or treatment procedure(s) involves some risks and no guarantees or promise can be made concerning the results of my procedure(s) or treatment(s). Although rare, unexpected severe complications with and diagnostic or treatment procedures can occur and include the remote possibility of Infection, bleeding, drug reaction, blood clots, nerve injury, loss of limb function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of diagnostic or treatment procedure(s) and that additional or specific risk have been identified: _____

I hereby consent to the diagnostic or treatment procedure(s) checked above and authorized that it be administered by Joseph Ibrahim, M.D or his/her associates, all of whom are credentialed to provide the above services at his health facility. I also consent to an alternate type of diagnostic or treatment procedure(s), if necessary, as deemed appropriate by them.

I acknowledge that I have read this form or had it read to me, that I understand the risks, alternative and expected results of the diagnostic or treatment procedure(s), and that I have ample time to ask questions and to consider my decision.

Date:_____ Witness:_____ Patient Signature:_____ Signature of Legal Guardian or Healthcare Representative:_____
Relationship to patient _____

Patient Release to:_____ Relationship to Patient:_____

No Driver:

I, _____, certify and acknowledge that I do not have a driver available after my procedure. I also understand that I will be kept in recovery for a minimum of 45 minutes unless otherwise instructed by my physician.

Physician's Certification:

I, _____ M.D., certify that I have explained the specified Procedure(s) and the attendant risks, to the above named Patient, and/or Legal Guardian or Healthcare Representative who has signed the above Consent.

Date:_____ Signature:_____

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PRE-OP QUESTIONAIRE

Date of Visit:_____/_____/_____

Name (please print): _____

Date of Birth:_____/_____/_____

1. Please list all medications that you are currently taking:

   _____

   _____

2. Since your last visit, have you been hospitalized with any illness, injury or infection? ❑ No ❑ Yes
   If Yes, please explain: _____

   _____

3. Are you allergic to any medication(s) or X-Ray/ Contrast dye? ❑ No ❑ Yes
   If Yes, please explain: _____

   _____

4. Did you stop taking Aspirin, Coumadin or Plavix **7 days** prior to your procedure? ❑ Yes ❑ No ❑ N/A

5. Are you or do you think you may be PREGNANT?
   ❑ N/A ❑ No ❑ Yes

IF YOU ANSWERED YES, PLEASE NOTIFY THE DOCTOR.