Greensboro Rejuvenation
THE CENTER FOR INTEGRATIVE HEALTH & WELLNESS

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Spinal Cord Stimulation Trial

Date _____/_____/_____ DOB:_____

Time: _____AM / PM ACCOUNT#:_____

1. I consent to the performance upon _____ the following procedure: Spinal Cord Stimulator Trial (8 electrode contact lead is passed through a needle in my mid to low back. This goes into the spinal epidural space. Goal is to substitute regular pain sensations for a sensation that is more tolerable.)

2. I understand that this procedure is to be performed under the direction of **Dr. Shawn Dalton-Bethea**.

3. The nature and purpose of this procedure and the reasonable (1) alternative methods of treatments (if any), (2) risks, (3) effect of no treatment, and (4) possibility of complications have been fully explained to me in terms I understand.

4. Information was provided to me and my questions were answered in terms that I understand, in order to make an intelligent and informed consent to the procedure.

5. I agree that no guarantee of results, success or cure has been given to me.

6. Risks and/or complications may include, but not limited to: bleeding, infection, increased pain, seizures, dural puncture, spinal headache, nerve injury, allergic reaction, paralysis and death.

7. We use Diprivan during the procedure for sedation. Risk of respiratory depression as well as drop in heart rate and or blood pressure can occur. If these symptoms were to occur, we would give you plenty of IV fluids and administer resuscitative medications if necessary. Those with egg allergies cannot be given Diprivan.

8. I understand that during the course of the procedure **Dr Shawn Dalton-Bethea** may consider it necessary or advisable to perform procedures or to render medical treatment in addition to that named in paragraph (1) because of conditions which may not be foreseeable. I therefore consent to the performance of such additional treatments and/or procedures as are deemed necessary or advisable.(Example would be IV placement or administration of medications such as Toradol and/or Benadryl

Signature of Physician	Date
Signature of Patient	Date
Signature of Person Responsible & Relationship	Date
Signature of Witness	Date