Neural Prolotherapy Informed Consent

You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

I have been advised of the following:

1. This procedure is an established technique for reducing pain.
2. This technique requires an injection of a 5% dextrose solution.
3. Multiple injections are done along the subcutaneous nerves. It has been established that irritation to a nerve that supplies sensation to the skin may also cause dysfunction and pain to the tissue underneath. The procedure has been used on thousands of patients and has been proven generally safe. Adverse reactions and severe complications are rare.
4. This treatment may decrease pain but may not completely eradicate it.
5. Multiple treatments may be required to achieve the patient's desired reduction and/or elimination of pain.

I have been advised that the alternatives to this procedure include:

- Do Nothing
- Physical Therapy
- Pharmaceutical Management
- Surgical Intervention
- Osteopathic or Chiropractic Manipulation

I understand that any procedure has inherent risks associated with it. I have been advised that the possible risks and complications of injections may include, and are not limited to:

- Immediate pain at the injection site
- Allergic reaction
- Spinal cord injury during any treatment over the spinal column
- Pneumothorax (partial or complete collapse of the lung)
- Infection at the injection site
- Injury to nerves, arteries, veins, and muscles at the injection site
- Temporary or permanent nerve paralysis
- Death from complications of the treatment
- There may be no effect from the treatment

Your signature below indicates that:

- You understand the information provided on this form and agree to the procedure.
- Your physician has adequately explained the procedure(s) set forth above to you.
- You have received all the information and explanation you desire concerning the procedure.
- You authorize and consent to the performance of the procedure(s).

Patient Name (printed): _____

Patient Signature: _____ Date: _____