

CONSENT FOR NEUROLYTIC NERVE BLOCK PAIN MANAGEMENT

I, _____ [print patient's name], have chosen to have a Neurolytic Blockade performed to alleviate my pain. I understand that the Neurolytic Blockade in addition to blocking my pain might also inhibit or damage other nerve fibers, which serve useful functions, and in so doing may alter my lifestyle or bodily functions. I understand all precautions will be taken to prevent this, but in view of the severity of my pain and the necessity to destroy the nerves conducting the pain pathways, I have accepted this risk and agree to proceed with the performance of the Neurolytic Blockade by _____ [print physician's name] and/or his/her associates. I understand that other specialists in the field of pain medicine with similar training and skill are available, but I have chosen to proceed with _____ [print physician's name] and/or his associates. I am aware that by receiving this nerve block that it is my responsibility to follow all post procedure instructions and therapy as ordered by the physician.

Physician Signature

Date and Time

Witness Signature

Date and Time